The Modern Hospital

MARCH 1954

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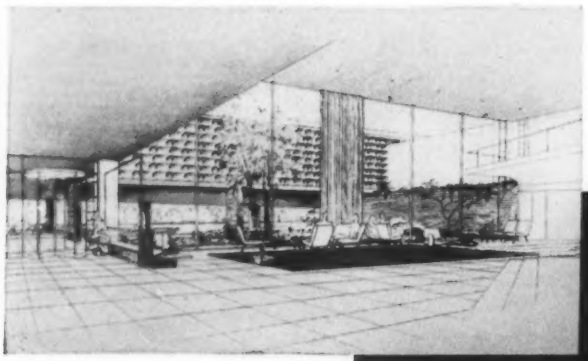
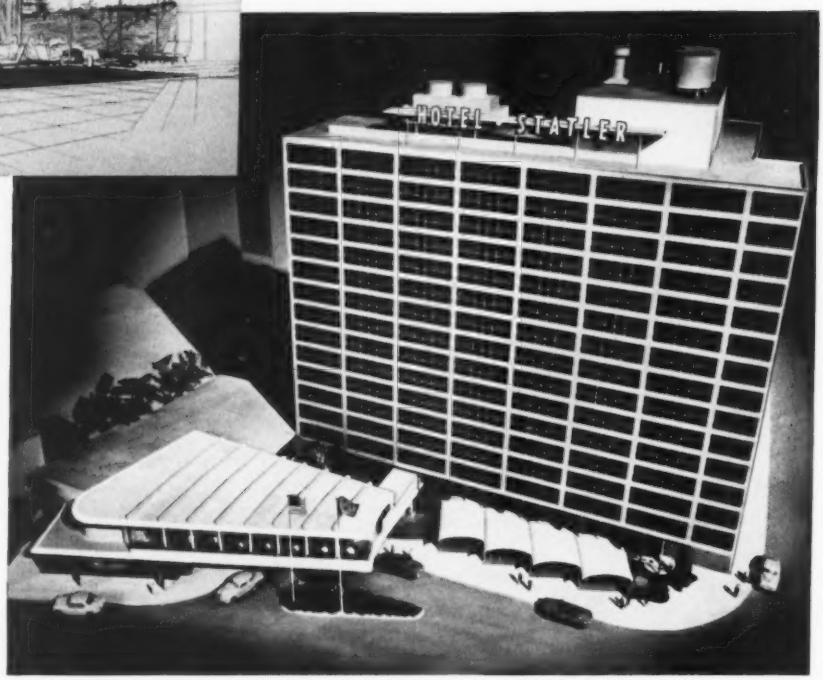


In the exciting new Hartford Statler the Garden Court between lobby and building exterior is open to a sky view



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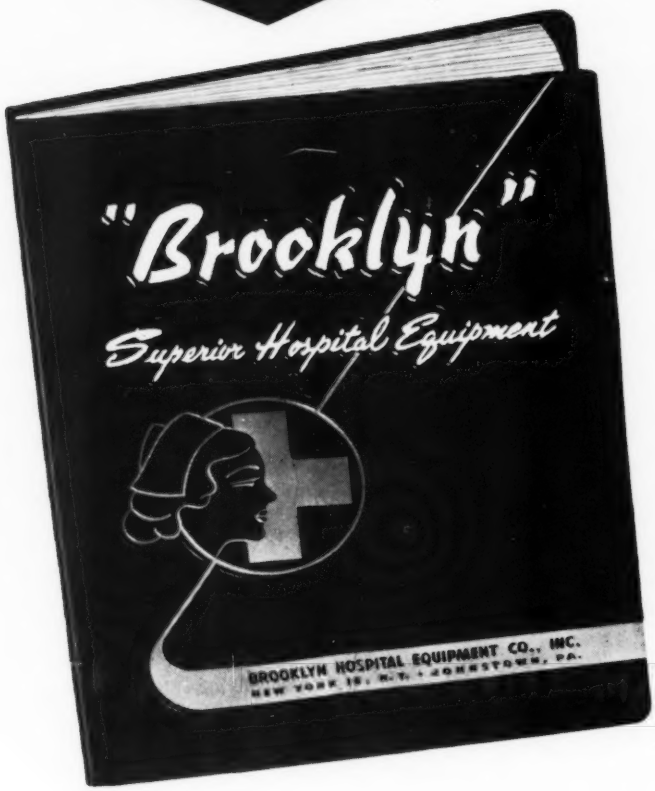

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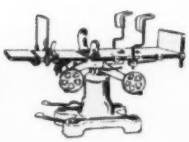
HOSPITAL & PHYSICIANS' EQUIPMENT 

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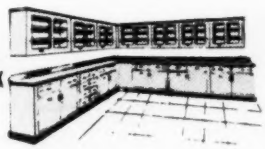
HOSPITAL CASEWORK 

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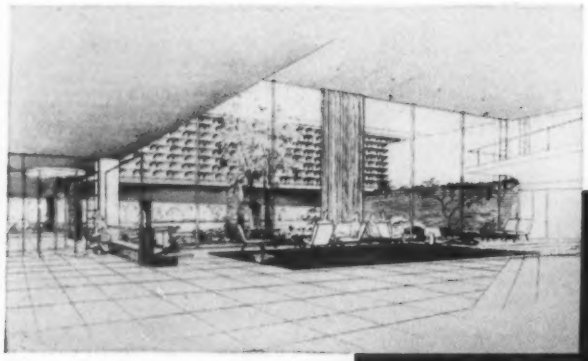

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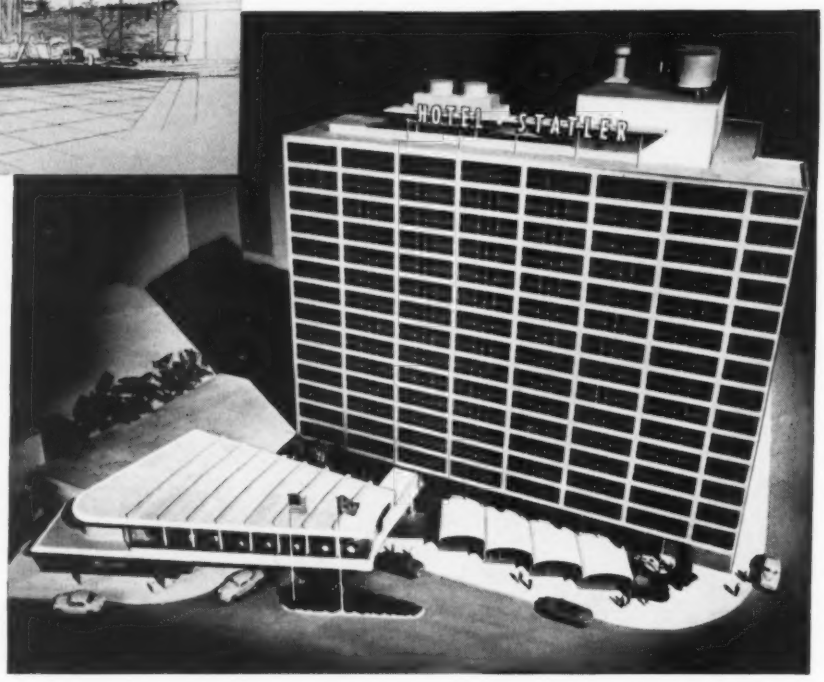

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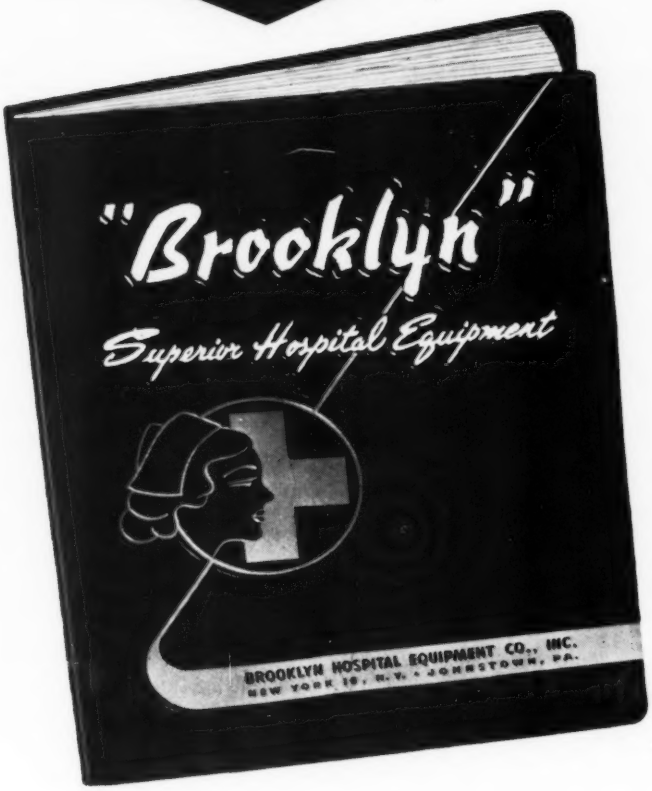

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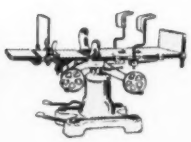
HOSPITAL & PHYSICIANS' EQUIPMENT 

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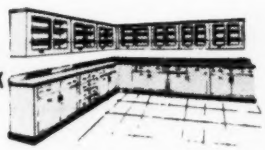
HOSPITAL CASEWORK 

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MARCH 1954

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MEDICINE AND PHARMACY

FOOD AND FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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AMONG THE AUTHORS


R. F. Schinderle

R. F. Schinderle is manager of the business and admitting offices at St. Francis Hospital in Peoria, Ill., where he has developed the "quick credit check" system described in his article on page 82 of this issue. "At the time we instituted the credit check here," Mr. Schinderle said, "we were having a very serious accounts receivable problem. Our accounts receivable picture has improved considerably since that time. I personally believe it is the result of the changes that we made." In instituting the credit check system, Mr. Schinderle has worked closely with C. L. McCalip, manager of the Credit Bureau of Greater Peoria. According to M. L. Heacox, public relations director of the Associated Credit Bureaus at Anderson, Ind., the system is also being used successfully in a number of other communities.


Dr. Juul C. Nielsen

Dr. Juul C. Nielsen, whose description of the Larue D. Carter Memorial Hospital at Indianapolis appears on page 73 of this issue, is superintendent of the hospital, which is a part of the University of Indiana Medical Center, and also medical director of the Indiana Council for Mental Health. A diplomate of the American Board of Psychiatry and Neurology, Dr. Nielsen is clinical professor of psychiatry at the University of Indiana School of Medicine. A graduate of the University of Nebraska School of Medicine at Omaha, Dr. Nielsen took postgraduate training at the University of Colorado Psychopathic Hospital. Before moving to the University of Indiana in 1952, he was superintendent of Hastings State Hospital at Hastings, Neb.


Florence E. Merriam

Florence E. Merriam is director of home economics for the National Association of Frozen Food Packers in Washington, D.C. A graduate of Kansas State College, Manhattan, Miss Merriam spent four years as a home economics consultant, home service representative, and director of home service for the Gas Service Company of Kansas before taking over her present position with the National Association of Frozen Food Packers. She is a member of the American Home Economics Association. Her article on page 118 of this issue discusses the advantages and economies that are possible through the use of frozen foods in institutional food service.


Roslyn Lindheim

Roslyn Lindheim, whose report of a nationwide survey of various kinds of facilities for outpatient medical care begins on page 56 of this issue, is an architect whose practice centers in Berkeley, Calif. She is a graduate of Radcliffe College and Columbia University School of Architecture, where she wrote her thesis on community hospital and health center design. With Dr. Leonard Greenburg as consultant, Miss Lindheim won second prize in The Modern Hospital's competition for design of small hospitals and health centers in 1945. Miss Lindheim has been a lecturer at the Museum of Modern Art in New York City, and at Pratt Institute. Last year, she was awarded a fellowship grant from Columbia University to tour the United States, studying how new developments in medical care and new forms of medical organization are affecting the architecture of health facility buildings. The article in this issue of The Modern Hospital is the first report of her studies, about which she is writing a book.

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★	Travert 10%-Electrolyte No. 2	57.0	25.0	—	50.0	25.0	—	6.0	12.5	Travert 10%	Any
	Travert 10%-Electrolyte No. 3	63.0	17.5	—	150.5	—	70.0	—	—	Travert 10%	Any
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Reader Opinion

Pioneer in Home Care

Sirs:

The extramural hospital program, popularly known as Home Care, toward which I strove for a period of many years and was able to inaugurate on a pioneering basis in Montefiore Hospital, New York City, on Jan. 1, 1947, was a response to many stimuli from the pages of hospital history. In this brief communication I would like to deal with one of them which emanated from a modest and self-effacing orthopedist who, responding to the continuing needs of his ward patients following their discharge, organized in 1933 what he called the Home Visiting Rehabilitation Society. His idea fitted in with my plans and, though the organization was short-lived, it made a lasting impression on my mind and had something to do with the elaboration of the final home care program which was established here more than a decade later. In this brave but weakly supported endeavor, the late Dr. Victor Jacques Jacobsohn gathered around him various members of his family and friends, and a few interested individuals from the only voluntary general hospital for prolonged illness in existence, where "incurability" was never accepted as a working hypothesis. Dues of $2 a year were expected to carry the financial burden. The effort commanded no response from the larger world of philanthropy. Louis Kraft, who was director of the Jewish Welfare Board, was elected president and the organization served a small number of patients during its brief career of activity. Money was scarce in the depression years and extramural projects were frowned upon as an extra financial burden.

Dr. Jacobsohn died after a prolonged illness in 1940 but his deep concern for the underprivileged sick remained as an inspiration to his colleagues. In response to the crying needs of the sick he conceived an idea which gathered strength through the years. He did not live to see the flowering of the seeds he planted. Others, of more solid standing, added their words and deeds of encouragement in later years, like Haven Emerson, John C. A. Gerster, Arthur Jones, Arthur Bookman, Louis Leiter, Daniel Laszlo and, most recently and most forcefully, Martin Cherkasky. There are now many programs in this country which are the direct descendants of the original Montefiore Home Care Program and the literature on the subject is growing and expanding. It is pleasant to pay tribute to the memory of the warmhearted and kindly Dr. Jacobsohn two decades after his modest contribution conferred on him this well earned mite of immortality.

E. M. Bluestone, M.D.
Consultant
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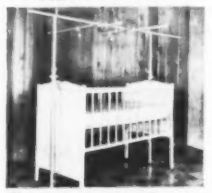

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Doctors, Nurses and Notes

Sirs:

Two articles in the October issue of The MODERN HOSPITAL have excited a great deal of comment here and I would like to know if we could obtain about 24 reprints of John Gorby's article entitled "Nurses' Notes Cost Money" and also Daniel Schechter's article, "As Doctor Sees Nurse—and the Same to You, Sir." We are very much interested in the first of these articles for this problem of nurses' notes has been approached from many angles by our medical staff.

I am highly in sympathy with the idea for I believe that much of the material nurses spend hours putting in the record is of no value to anyone. To date, however, I have not had sufficient time to do very much research on the problem and, accordingly, was well pleased to see that someone else had found a solution. I have written to Mr. Gorby to see if he would be so kind as to furnish us with a sample of the form he developed. I think he really has something.

Incidentally, there are other aspects of the patient's medical record that probably could use some type of simplification. In a large hospital with a house staff the keeping of medical records is not much of a problem but in a place like this, where all records are kept by the attending physician, we have a great deal of trouble getting records written at all. A simplified patient's record would be a great asset to us.

Robert A. Bradburn
Grace Hospital
Hutchinson, Kan.

Myers on Surgery

Sirs:

Your excellent article ["Who Should Do Surgery?" by Robert S. Myers, January 1954 Modern Hospital] should be brought to the attention of hospital trustees and others responsible for the staffing of hospitals. . . . Practically all the new hospitals here are or will be operated by boards of trustees who, as a rule, have had no previous experience with the problems of staffing and operating hospitals. They would be greatly aided by an opportunity to read your article. . . . We could use a large number of reprints effectively in this state.

John A. Ferrell, M.D.
Executive Secretary
North Carolina Medical
Care Commission
Raleigh, N.C.

Sirs:

I am impressed with the article by Dr. Myers. I believe this is a splendid article. If reprints are to be made I would appreciate being advised so that we might order a quantity of them.

F. C. Leupold
Administrator
Jamaica Hospital
Jamaica, L.I., N.Y.

Sirs:

The article is excellent. This is such a critical subject that I want the members of our board of directors and medical staff to read it. . . . It is my feeling that the standards set forth are not too stringent and that we must continue to cut away at the problem. . . .

Robert E. Griffiths
Administrator
Burlington Memorial Hospital
Burlington, Wis.

Sirs:

The article is excellent. Our execu-

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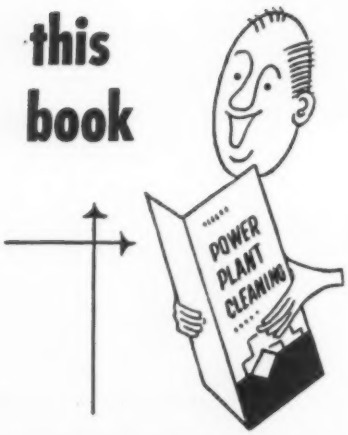

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MAINTENANCE IN STEAM CENTRAL STATIONS—Such as cleaning and descaling condensers, pre-heaters, feed water heaters, compressors, heat exchangers, etc.

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HOW TO OPEN UP SCALE-CLOGGED WATERWAYS—with specialized water-mixed Oakite materials for descaling passages inaccessible to rod or drill.

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MATERIALS • METHODS • SERVICE

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tive committee would like you to send us 100 copies.

Kenneth B. Babcock, M.D.
Director
Grace Hospital
Detroit

Sirs:

Your article was of great interest to me. I would like very much to have reprints for distribution to some of the hospitals of Kentucky. It is of special value in setting up criteria for staff privileges in the smaller hospitals.

Asa Barnes, M.D.
United Mine Workers of America
Welfare and Retirement Fund
Louisville, Ky.

Sirs:

Our hospital is in the midst of a reorganization, and this article fits in nicely with what our department of surgery has been discussing. We would appreciate it if you would send reprints for distribution to members of the department. . . .

John H. Shephard
Administrative Assistant
Stormont-Vail Hospital
Topeka, Kan.

Sirs:

I feel that you have covered the subject exceptionally well, with sound reason and logic. . . . I should like copies for distribution among members of the executive committee of the staff. . . .

H. M. Walton, M.D.
White Memorial Hospital and Clinic
Los Angeles

Sirs:

The writer was very much interested in your article. . . . If possible, I should like to have reprints to furnish to members of the credentials committee.

D. W. Hartman
Administrator
Williamsport Hospital
Williamsport, Pa.

Sirs:

Our trustees and medical staff have been studying this question for some time. The article by Dr. Myers has undoubtedly helped in clarifying some of our problems so that a satisfactory solution was worked out in a joint meeting held last week.

Godfrey Crosby
Administrator
Brattleboro Memorial Hospital
Brattleboro, Vt.

This is a small sampling of many, many letters commenting on Dr. Myers' article and asking for copies for board and staff members.—ED.

Chronic Disease Problem

Sirs:

I have just read Ray Brown's excellent article entitled "Geriatrics Is a General Problem: The Criterion Is Medical Need—Not Age" which appeared in the January 1954 issue of The MODERN HOSPITAL.

This article deals with an important problem which has not yet been solved. The subject was discussed by the members of the North Carolina Medical Care Commission at the quarterly meeting held Dec. 18, 1953, and a special committee was appointed to study chronic diseases and the type of program and facility that should be developed in this state. A large number of so-called "convalescent homes" have sprung up in the state that cannot qualify as hospitals. They are often operated in buildings originally constructed as residences and oftentimes by nurses. They are operated for profit. An effort to include such institutions along with the commission's program of licensing hospitals was presented to the 1953 legislature, but failed.

Mr. Brown is correct in stating that the state hospital agencies, in the use of Hill-Burton funds, have tended to concentrate on local general hospitals, many of which are small. The general interest in hospital development in this state, stimulated by the work of the Duke Endowment, has been in the general hospital. The state hospital agencies and the Hill-Burton program should not be blamed entirely for failure to develop chronic disease hospitals. The fact is that there has not yet been a *bona fide* sponsor in this state for a chronic disease hospital. A number of medical and hospital authorities in this state believe the local general hospital should deal with the chronic disease problem. Others, for financial reasons, believe that state-owned and operated chronic disease hospitals should be provided along the line followed in providing hospitals for mental diseases and hospitals for tuberculosis.

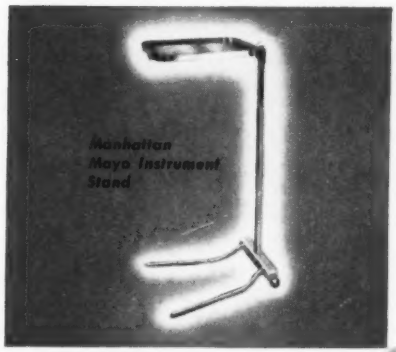
John A. Ferrell, M.D.
Executive Secretary
North Carolina Medical
Care Commission
Raleigh, N. C.

GUARD AGAINST EXPLOSION HAZARDS

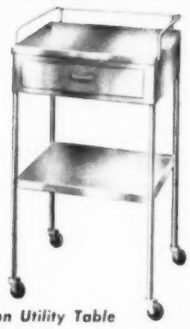
. . . with these electrically-conductive operating room units

• Many prominent institutions have standardized on these Blickman-Built operating room units. Their highly-polished stainless steel surfaces ground static charges effectively through electrically-conductive casters and floor tips. Sturdy, seamlessly welded construction assures long service life. Elimination of dirt-collecting joints and crevices facilitates cleaning. Before buying operating room equipment, see and compare the advantages of "Blickman-Built."

SEND FOR BULLETIN 9 ORC . . . . illustrates and describes more than 50 different Blickman-Built stainless steel units of operating room equipment.



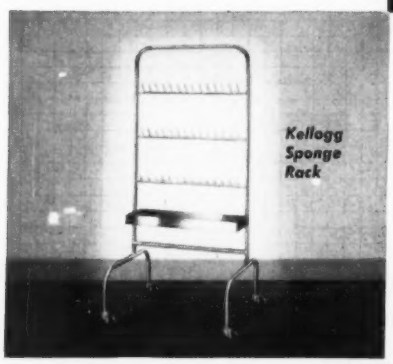
Howard Instrument Table



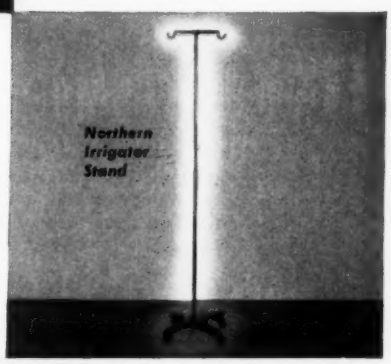
Ferguson Utility Table

Graystone
Curved Instrument Table

Baker Solution Stand



Dawson Dressing Carriage



S. BLICKMAN, INC., 1503 Gregory Ave., Weehawken, N. J.

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 29-31 and to the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., Booths No. 28-29-30, April 7-9.

Roving Reporter

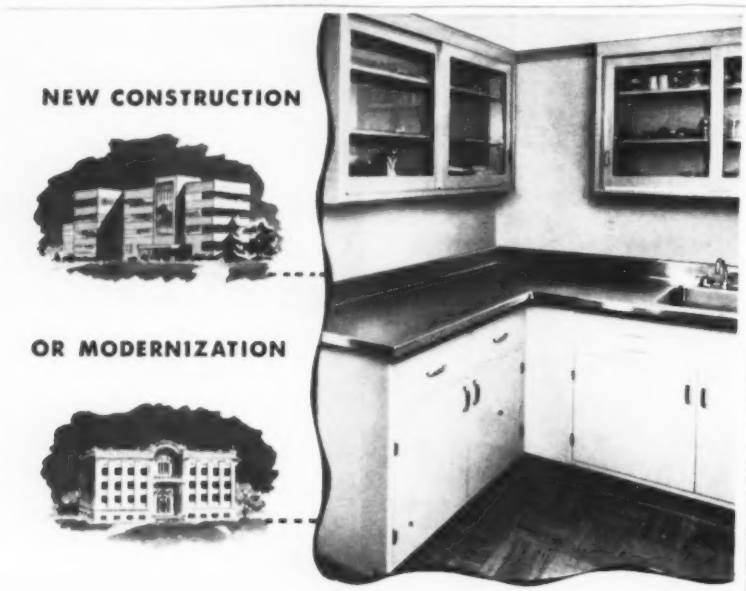
AWARDS FOR SERVICE

Springfield Hospital, Springfield, Vt., recently adopted the policy of awarding service emblems in the form of pins to the personnel employed five consecutive years or longer.

A special dinner was given by the executive committee of the board of trustees to the 15 employes who were now eligible. These represented a total of 140 years of service. A pin was presented to each by the president of the board.

Our emblems are inscribed with the name of the hospital, "Loyal Service," and the number of years (in 5's or multiple of 5's).

It is the plan to give this form of recognition to each employe on the exact day of his anniversary of employment and give a dinner or other form of celebration annually for the new members, including the senior ones.—N. GERTRUDE SHARPE, *administrator, Springfield Hospital, Springfield, Vt.*



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Call on your Maysteel field representative — or write for his name — he will work closely with your planning board, architect or engineer. No obligation, of course.

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NURSE RECRUITERS, TAKE NOTE

While the recruiting index is yet to be determined, one may hazard a guess that the amateurs at one St. Louis school may have outdistanced certain professionals.

For a number of years the Jewish Hospital School of Nursing turned to an advertising agency or a public relations firm for its mailing piece to prospective students, and the resulting brochure was a slick "package" job. This year the school has done its own photography (fair) and its own copy (excellent) for the promotion piece, turning only to an artist for layout suggestions and to a printer for typographical advice.

A highly original touch is the background for Page 2, the chief picture page of the four-page piece. Here small snapshots of student nurses engrossed in their professional tasks are inset into a blue and white checked background. You've guessed it—the background is a photograph of the checked blue and white gingham from which students' uniforms are made. The material has been draped slightly so that the folds distort the pattern, now intensifying, now fading the blues.

Here's a sample of the copy, which is sparse, fast and staccato:

"Your studies go beyond the textbook. As a student nurse there is the satisfaction of putting theory to work . . . of learning while doing. You'll gain inspiration and know-how from association with professional people in medicine and the allied fields. The Medical Center becomes your classroom . . . you'll study and observe at firsthand all phases of medicine. You'll have the unique opportunity to find out—while still in school—the facet of nursing which appeals to you most as a career." In this instance, the the dots do not denote ellipses, rather the breathlessness that results from speedy reading.

The switch to amateur status in recruiting propaganda could start a trend. The school at Jewish Hospital "hoped to give the brochure individuality and freshness in this way," Catherine Blomes, R.N., field representative of the school, declares.

For Efficiency, Economy and Dependability...rely on

HUEBSCH

WASHERS and DRYERS

Huebsch, the world's largest manufacturer of open-end drying tumblers—and now manufacturing the newest and finest open-end washer—offers the equipment you need to give satisfactory service at a profit. Ask your Huebsch representative for full details—or write directly to us.

HUEBSCH OPEN-END TUMBLER
Choice of four sizes—Available in both laundry and drycleaning models

HUEBSCH OPEN-END WASHER
37" x 18" cylinder; rated capacity: 50 pounds

HUEBSCH Originators

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Division of
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Makers of the famous Huebsch Open-End Tumblers • Open-End Washers
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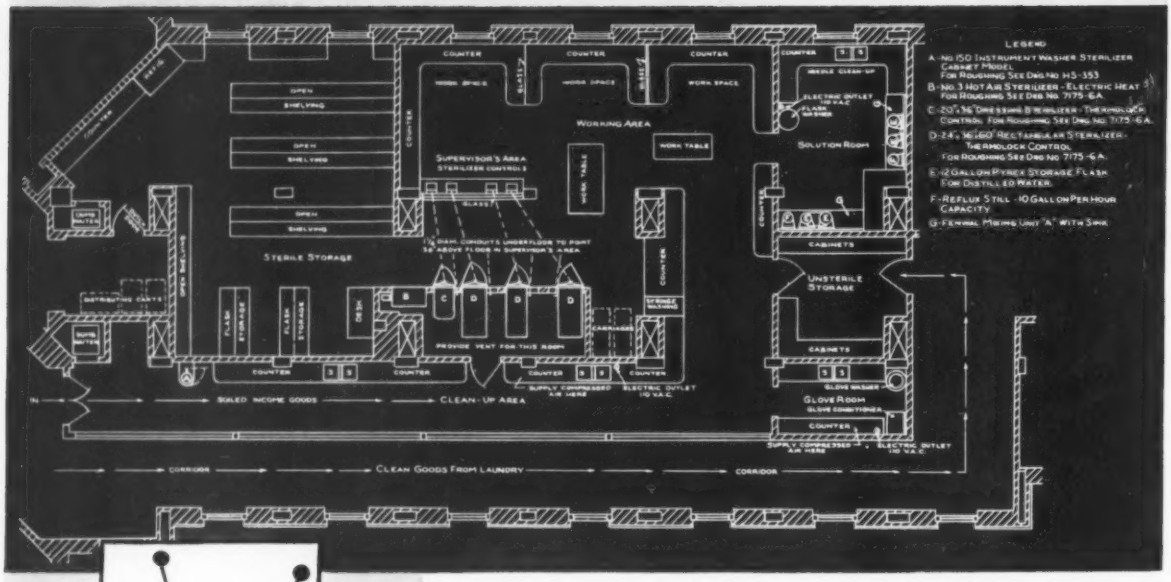
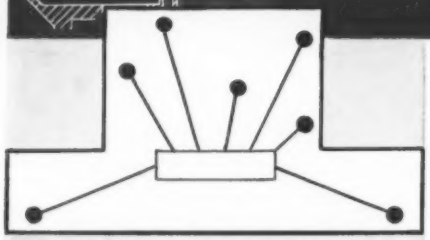
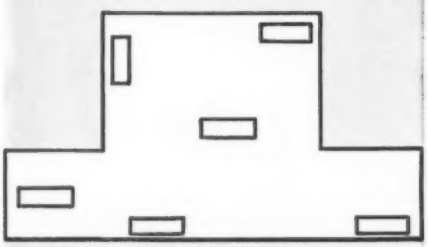
Feather Renovators • Double Sleevers • Collar Shapers and Ironers
Garment Baggers • Cabinet and Garment Dryers • Washometers
Spring-Type Filters

A CENTRAL STERILE SUPPLY CUTS COSTS





Typical Central Sterile Supply centralizes facility for greatest economy.



Decentralized system means increased equipment and personnel expense.

SAVES IN EQUIPMENT — PERSONNEL — TIME

A modern CENTRAL STERILE SUPPLY DEPARTMENT reflects its economies in most all phases of hospital operation. Regardless of bed capacity, the preparation, sterilization and distribution of materials in a central facility requires less personnel, less equipment, and saves time.

- **NO OVER-EQUIPPING** — Equipment limited to actual units indicated to process routine and emergency supplies.
- **STANDARDIZED PROCEDURES** may be placed under supervision of one competent authority. Greater safety control . . . less possibility of error . . . less waste.
- **NON-SKILLED WORKERS** and lay aids can assume routine manual duties and thus free highly trained nurses for floor and bedside duties.
- **ESTABLISHES FOCAL DISPENSING CENTER** — Serves to simplify requisition and inventory control . . . a constant check against waste and loss of stocked supplies.

PLAN ANALYSIS . . . Castle's gratis service

Let our experienced Planning Department analyze your present floor plans or proposed construction blueprints. Let us offer recommendations as to the **which** — **where** — **how** and **cost** of one adequate installation . . . without charge or obligation.

WE INVITE YOUR INQUIRY

WILMOT CASTLE COMPANY

1175 UNIVERSITY AVENUE
ROCHESTER 7, NEW YORK

The Hausted Manufacturing Company Announces A New Sales Policy

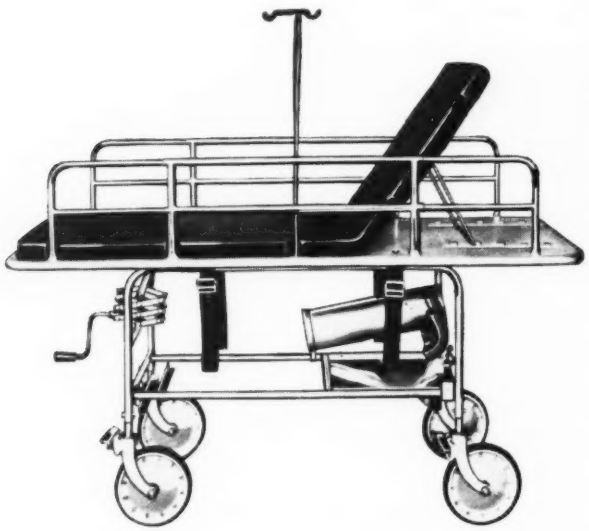
As a business grows, its methods of doing business must grow with it. We have reached a point in our own growth where we are making a change in our sales program that, we are convinced, will enable us to serve our customers better. We have decided, therefore, to adopt a policy of *direct factory to hospital selling.*

Our main interest in adopting this *direct-selling* sales policy is to give every hospital the maximum in service at a minimum in price.

The Hausted line of Wheel Stretchers have become the quality line in their field—ranging from the regular Standard Stretcher to the Multi-purpose O.B. and Examining Table and the One-Way and Two-Way Slide and Tilt Easy-Lifts. In addition to our high quality in materials and manufacturing methods we are vitally interested in the high quality of use that hospitals receive from our stretchers.

We have found that we can maintain these high standards of quality better and even add to them when we are in *direct contact* with our hospital customers. Therefore, *we will now sell and service our customers directly from our factory.* We know that this will result in real advantages to the hospitals now using our equipment and to the hospitals who will join these hundreds of others that have increased their wheel stretcher efficiency through the use of the Hausted equipment.

We urge you to contact us direct at our Medina, Ohio main office in regard to future purchases of the Hausted wheel stretchers. We can promise increased service and increased satisfaction through direct contact with our factory-trained sales personnel whose manufacturing know-how will result in maximum efficiency in your wheel stretcher use.



COMPARE AND YOU'LL AGREE THAT HAUSTED STRETCHERS GIVE MAXIMUM EFFICIENCY

The entire Hausted line of multi-purpose stretchers are designed to give better patient-handling and to decrease personnel costs. One nurse does the job of many when you use Hausted stretchers. We invite your inquiries about the Standard Stretcher, O.B. and Examining Table, and Easy Lift Stretcher.

For Information Contact Us Direct

THE HAUSTED MANUFACTURING COMPANY

Medina, Ohio

Sensational New Aloe Vacuum Pump

Provides continuous, mild suction for drainage and aspirating technics - only **$29.50**

Bottle Holder keeps drainage bottle safe from accidents.

This efficient new vacuum pump has all the power necessary for mild drainage and aspiration, yet the power unit itself occupies only $2\frac{1}{2}$ inches of space, and is offered at a fraction of the cost of conventional pumps. Dial control makes possible variable vacuum from 2 to 15 inches; air displacement up to 600 cubic centimeters per minute. Supplied complete with special float which fits $\frac{1}{2}$- or 1-gallon Mason type jars. The unit is sealed in a black case mounted on machined aluminum base. Base mounted on sponge rubber feet — will not "crawl." An aluminum bracket is supplied to attach pump unit to bed rail. Unconditionally guaranteed for one year.

JB906—Aloe Vacuum Pump, for operation on 110-120 volts, 60 cycle, A.C. only. With safety float, tubing, cord and plug: only.... $29.50

Aloe Out-O-Way Drainage Bottle Holder

Recommended for use with Aloe Vacuum Pump listed above. Eliminates accidents with drainage bottle; fastens to angle iron of bed by means of adjustable catch. Holds gallon Mason jars, Fowler bottles, or hospital food jars.

JS3507—Aloe Out-O-Way Drainage Bottle Holder,

as described, each	$ 5.00
In lots of 6, each	4.50
Per dozen	50.00

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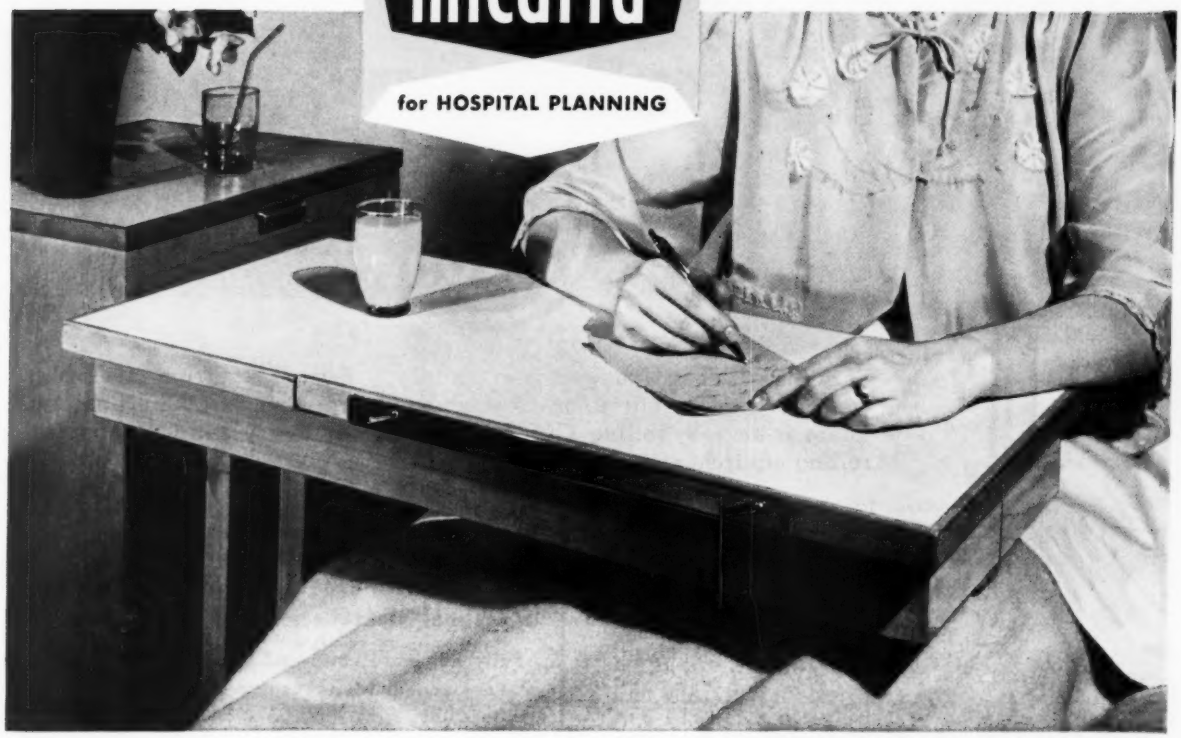

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MICARTA® is the long-run, low-cost solution to hospital problems where tables, counters and other functional surfaces must withstand the rigors of constant use. The tough plastic surface of this efficient and decorative material provides a remarkable resistance to the bugbears of hospital maintenance—stains, burns, scars or dents.

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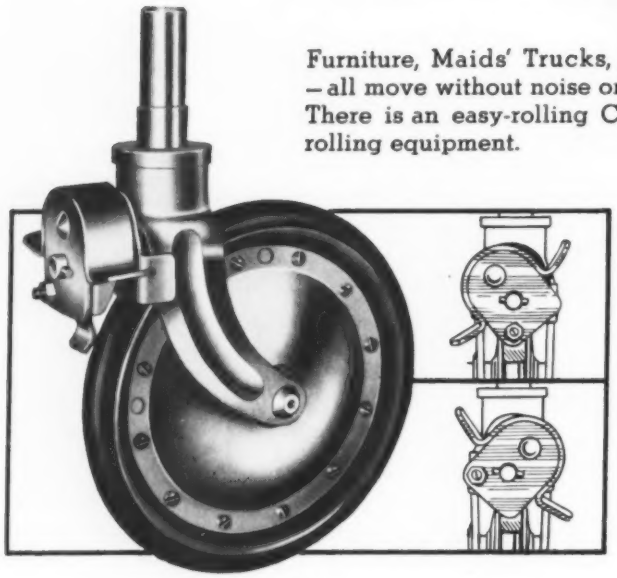
Furniture, Maids' Trucks, Food and Tray Trucks, Instrument Tables — all move without noise or effort when equipped with COLSON casters. There is an easy-rolling COLSON caster for every kind of hospital rolling equipment.



Casters With Wheel and Swivel Lock for Wheel Stretchers, Shelf Trucks, etc.

Fully adjustable cup and cone ball bearings in wheel and swivel bearings. Double steel disc wheels have demountable cushion rubbber or semi-pneumatic tires. Brake lever locks swivel for straightaway operation or wheels *and* swivel to hold equipment stationary. Available in 8" and 10" wheel diameters with or without locks.

Casters for Metal Furniture and Rolling equipment

Equipped with universal metal expansion adapters these casters are ideal for replacing worn, hard-rolling casters on all kinds of lightweight equipment with tubular legs. Full ball-bearing construction for easy, quiet operation. In 1 5/8", 2" or 3" diameters — with wheel brakes if desired. Conductive rubber models available.

Bed Casters

Easy-rolling, easy-turning COLSON bed casters prevent scratching or gouging of floor surfaces. Adjustable adapters for all popular sizes of round or square tubing used in beds. Full ball-bearing swivel construction, hardened bearing surfaces and oversized stems assure many years of trouble-free service. Wheel sizes are 3", 4" and 5". Conductive rubber models as well as wheel brakes are available.

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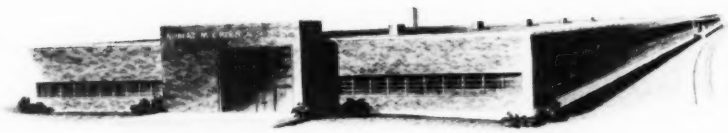

This new factory of Robert M. Green & Sons, Inc., has just been completed. It is located at Nesquehoning, Pa. There are more than 75,000 square feet of floor area and it is equipped with the most modern high-speed production facilities which make possible a radical cut in delivery time.

Long life and ease of cleaning are built into every piece of Greenline equipment. Rigid, one-piece construction is achieved by using heavy gauge stainless steel with seamless welds that are highly polished. When color is desired, high-grade carbon steel is enameled.

YOU will find many labor-saving features in this new Greenline of hospital equipment. It has been designed with the aid of leading hospital consultants, administrators, physicians and technicians.

This old company has had 78 years of experience in the fabrication of similar equipment. Two years ago it entered the hospital field. Now with a new plant and the latest production facilities, it is ready to provide you with hospital equipment under its trade-marked name—The Greenline.

FINEST QUALITY—LOW PRICE FASTER SERVICE

Each piece in The Greenline is designed to save steps or effort of the user and reduce clean-up time. Long-life is built in by its rugged construction and careful workmanship.

Yet the prices of The Greenline equipment will be no higher than competitive items. And you can obtain delivery in a few weeks instead of waiting several months.

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Send today for The Greenline catalog. It will give you complete information and specifications for each item in The Greenline.

In the design of special equipment, the engineering staff of Robert M. Green & Sons, Inc., are glad to offer their services. You can be assured by their help of obtaining the finest possible equipment, embodying your ideas and meeting your specific needs and problems.

THE GREEN LINE

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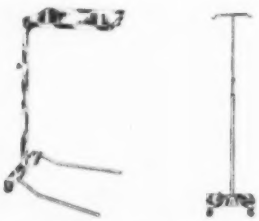

INS-02 Mayo Instrument Stand, adjustable from 39″ to 60″ by a pressure button. Made of all stainless steel. A popular piece of equipment used in most hospitals.

IRS-01 Irrigator Stand, adjustable from 72″ to 108″. All stainless steel.

UT-02 Utility Table is a popular type, being widely used in many hospitals. Constructed entirely of non magnetic 18-8 stainless steel. Casters are electrically *conductive*.

This new, electrically heated Food Conveyor incorporates several features that add to convenience in using, increase economy of operation and save time in cleaning. The smooth, one-piece top and wells of stainless steel are welded to eliminate joints and crevices while all corners are rounded.

KB-01 and SR-01 Kick Bucket and Sponge Receptacle. Both are equipped with non-marking encircling rubber bumpers and electrically *conductive* casters. Made entirely of gleaming stainless steel. Readily cleaned.

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There are 230 pages with illustrations and specifications of equipment now in The Greenline. For your convenience the catalog is separated into tabbed sections as follows:

Nurses Station
Hampers, Trucks
Autopsy
Physiotherapy
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Casework and Lab.
Nursery
Room Furniture
Food Conveyors
Soda Fountain
Index
Prices

Robert M. Green & Sons, Inc.
Nesquehoning, Pa.

Please see that I receive a copy of your catalog showing the new Greenline Hospital Equipment.

*Name*_____

*Title*_____

*Hospital*_____

*City & State*_____

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HOW TO SAVE $28.55 PER ACTIVE BED

in dressing costs per year

A saving of $2,227 a year . . . plus better technic and cost control. That's what a *Curity* Dressings Survey meant to St. Mary's Hospital in Grand Junction, Colo., a small hospital with 78 active beds.

. . . which shows that *Curity* Dressings Surveys mean real savings for small hospitals as well as large.

At St. Mary's, *Curity* Representative W. R. Eymer found several opportunities to improve dressings practice—at the same time saving $403 in O. R., $1,217 in O. B. and $607 on Floors!

For example, a change from all-gauze to Lisco® cotton-filled sponges would provide better hemostasis and patient comfort . . . while saving $17 a month. A recommended change in nursery pads would save $87 a month . . . and higher absorbency would keep babies' skin drier and healthier.

Because *Curity* hospital men are experienced in the *best* dressings practices, as well as the most economical, a *Curity* Dressings Survey can help you improve technic, give you more efficient cost control, and save you money.

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Any way you look at it . . . performance-proved B-P RIB-BACK SURGICAL BLADES contribute to the certainty of the surgeon's touch, as they provide him with dependable, uniformly sharp and enduring cutting edges.

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And Rib-Backs packaged in the new RACK-PACK provide further *economies* in time and labor for the O. R. Personnel. Blades from RACK-PACK to sterilizer in *a matter of seconds.*

It's Sharp

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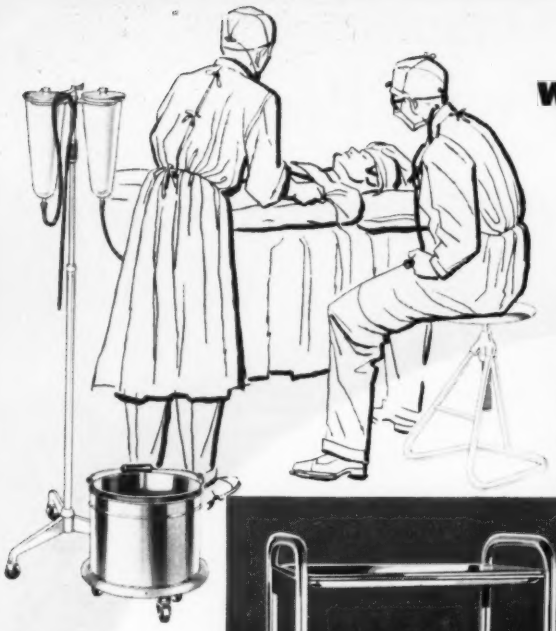

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ALUMINUM ALLOY

SURGICAL FURNITURE

MODEL A3142 Anesthetist's Table has two stainless steel trays and a friction-free stainless steel drawer. Also supplied with two drawers, one below each tray

safe SterilBrite aluminum frame construction conducts electricity better than stainless steel . will conduct any static charge. Aluminum will not produce a spark when struck by a piece of steel, flint, or stone. These features, together with the use of conductive rubber casters or conductive rubber-tired wheels, make SterilBrite furniture among the safest available.

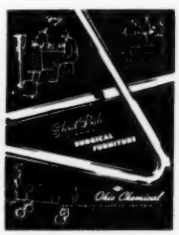
easy to handle Continuous tube aluminum alloy construction makes SterilBrite furniture unbelievably light in weight. Wheels glide on noiseless ballbearings for silent, smooth mobility.

strong This streamlined furniture is designed to provide perfect balance and stability, and it will support far in excess of any normal weight requirement.

beautiful and practical

Gleaming and permanently lustrous, this furniture needs no polishing is extraordinarily resistant to bumps, scratches and stains. Tops and shelves are of brightly polished sound-deadened stainless steel.

send for NEW catalog



OHIO

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
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Ohio Chemical & Surgical Equipment Co.
Madison 10, Wisconsin **Department MH-3**

Please send me illustrated catalog (No. 2125) on complete line of SterilBrite surgical furniture

Name.....

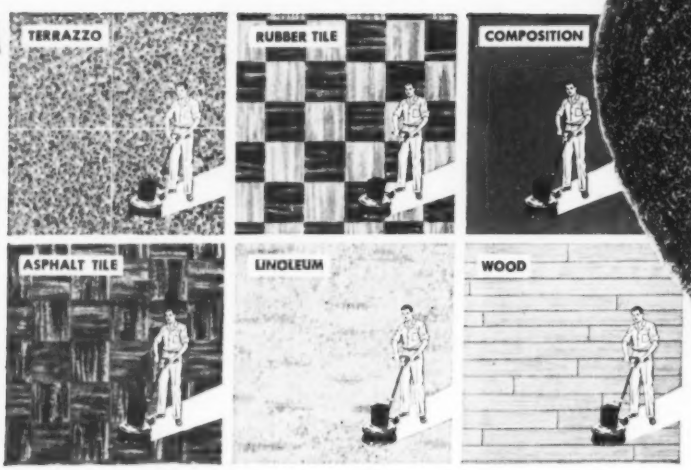
Title.....

Name of hospital.....

Address.....

City..... Zone..... State.....

You clean any type flooring *faster—better—more economically* with BRILLO FLOOR PADS



Brillo Floor Pads give extra-long service. After using, simply shake out the pad, *reverse and use again*

YOU GET CLEANER FLOORS with a longer lasting gloss at lower maintenance cost when you use Brillo Solid Disc Steel Wool Floor Pads.

Solid Disc Gives Greater Coverage! With a Brillo Floor Pad the entire surface of the pad works for you—cleans *all* the floor it covers . . . saves time. Cleans and buffs at one time . . . saves labor. You get cleaner floors with less swirl marks.

Lasting sparkle for your floors! Brillo Floor Pads speed the waxing process—bring out floor beauty quickly—because cross-stranded Brillo metal fibers give gentle abrasive action in every direction. A daily once-over with a dry Brillo Floor Pad easily removes dirt, grime, scuff marks—makes original waxing last much longer—avoids wax build-up—eliminates frequent stripping and re-waxing.

Efficient . . . easy to use! Simply place pad under brush of rotary floor machine. Operate as usual. Brillo Floor Pad stays in place . . . does not buckle . . . machine does not bounce. Sizes for every machine. All grades for every job.

Brillo Pads clean and polish Hardwood, Linoleum, Asphalt and Rubber Tile, Terrazzo, Composition

Available from your dealer in all grades and all sizes from 8" to 22" diameter

- **To remove ingrained dirt,** paint, varnish with liquid remover—Grade No. 3
- **To remove old wax,** excess seal—to prepare floors for waxing—Grade No. 2
- **To apply and burnish** wax or seal on floor surface—Grade No. 1
- **For daily removal** of dirt, excess wax, and to buff high polish—Grade No. 0

BRILLO SOLID DISC STEEL WOOL FLOOR PADS

BRILLO MANUFACTURING COMPANY, INC. · 60 John Street, Brooklyn 1, N. Y.

Without wet strength, paper towels fall apart quickly — so you use more to dry your hands. Too much wet strength, and the towel lacks absorbency — so again you use more towels to do the drying job.

But *Controlled* Wet Strength in Fort Howard Handifold Towels provides strength without sacrificing softness or absorbency, for quick economical drying. Stabilized Absorbency keeps Fort Howard Handifold fresh and effectively absorbent for over a year, enabling you to buy in economical quantities. And Fort Howard Acid Free paper feels better, is kinder to hands.

These are the "plus values" that add up to superior towel performance — when you specify Fort Howard! Call your Fort Howard distributor salesman today!

For 35 Years Manufacturers of
Quality Towels, Toilet Tissue and Paper Napkins

FORT HOWARD PAPER COMPANY
Green Bay, Wisconsin

THAT'S WHY

pure white

Fort Howard Paper Towels

GIVE YOU STRENGTH FOR GREATER ECONOMY!

Let One Room be the Judge

Here's an experiment you can't afford to miss. Take a small room . . . one that really needs painting . . . and test paint it with Barreled Sunlight Odor-Free Alkyd Flat or Semi Gloss.

YOU WON'T BELIEVE YOUR EYES

Just one coat . . . the easiest, fastest coat that ever went on the wall . . . leaves a smooth, uniform surface with outstanding hiding and "hold out" properties . . . a surface that looks like a two-coat job. Yes, and it's the most durable, practical surface that anyone could want . . . washable, scrubbable, even scuff marks wipe right off.

Odor-free, fast-drying, easy to apply with brush, spray or roller, Barreled Sunlight Alkyd Finishes . . . in white or wanted colors . . . will most certainly cut your painting costs and losses due to down time.

Try them. Test them. Let one room be the judge. Write for free color card and name of your nearest Barreled Sunlight distributor. Barreled Sunlight Paint Company, 30-C Dudley St., Providence 1, R. I.

Barreled Sunlight® Paints

In whitest white or clean, clear, wanted colors, there's a Barreled Sunlight Paint for every job

Does your Hospital have MODERN PROTECTION...

AGAINST EXPLOSION—FIRE HAZARDS!

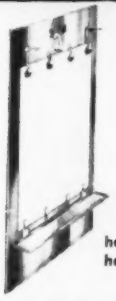
Exterior of Georgia Baptist Hospital in Atlanta, Georgia, which is equipped 100% with Appleton Electric Company Explosion-Proof Equipment

Safeguard your hospital with modern

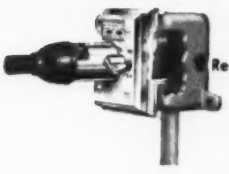
APPLETON

Explosion-Proof Equipment

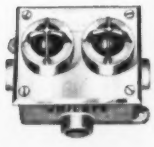
U. L. Approved for all hazardous areas in Class I, Groups C and D



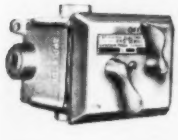
X-ray Film Illuminators for hazardous or non-hazardous locations.



Receptacle with Plug.



Two-gang Pilot Lights. Available in single gang and in combination with switch.



Two-gang Switch Unilet. Single gang model also available.

Portable Current Tap with Feed-in Plug.

● Up-to-the-minute *Appleton* design, unquestioned *Appleton* quality and proven *Appleton* trouble-free service are 3 good reasons why *Appleton* Explosion-Proof Equipment is being installed in fine new hospitals, everywhere.

Low overall cost is another good reason why *Appleton* Explosion-Proof equipment is the choice of alert architects and informed management for up-to-the-minute protection against spark-caused disasters.

Why not consult your electrical contractor today for a check up on the degree of protection in hazardous areas in your hospital? Ask him about the *extra benefits* of *Appleton* Explosion-Proof equipment for you.

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1743 Wellington Avenue • Chicago 13, Illinois

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Explosion-Proof Lighting Fixtures

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Announcing 3 New Corning DOUBLE-

New Bowls And Mug Save You Even More Money On Tableware Replacement Costs!

YOU asked for them! Ever since the introduction of Double-Tough Dinnerware last year, enthusiastic users have asked us to add other items to the line! Here they are: a new Double-Tough Soup Bowl, a Cereal Bowl, and a Beverage Mug—one with a handle your fingers can really get into! Like *all* CORNING Double-Tough Dinnerware, these new pieces are outstanding for—

Durability! Will not break when dropped from *twice* as high as the "breaking point" of most other ware. Handles are an integral part of the cups and mugs—will not break off. Rims are 50% stronger!

Cleanliness! Hard, vitreous surface leaves no hiding places for food or germs to lodge. No glaze to wear through. Dishes can be safely sterilized—heat won't crack or craze them!

Light Weight! Double-Tough Dinnerware is 20% lighter than most other institutional dinnerware. Trays of stacked dishes are easier to carry and safer to handle!

Good Looks! Gleaming white surface of Double-Tough Dinnerware never grows dull! The sparkle goes all the way through—can't wear off! All dishes decorated with green bands.

Add Extra Savings With CORNING DOUBLE-TOUGH TUMBLERS Reduce Glass Breakage More Than 50%!

Here's real proof of tumbler savings! York Research Corporation made a scientifically controlled study of tumbler breakage in leading New York hotels. They tested thousands of CORNING Double-Tough Tumblers against ordinary glass tumblers—using both kinds in regular hotel service. Results proved Double-Tough Tumblers outlasted ordinary tumblers from 3 to 4.3 times—would pay for themselves several times over from savings on breakage!

Special tempering makes CORNING Double-Tough Tumblers exceptionally resistant to impact damage—makes the rims super-resistant to chipping! Any tumbler that chips on the rim will be replaced—*free of charge!*

Thin and good-looking, these durable Double-Tough Tumblers come in four graceful shapes. Start saving on breakage, see your equipment dealer today.

Corning DOUBLE-TOUGH Dinnerware and Tumblers

made by the makers of **PYREX** BRAND *Ware*

Money-Saving Pieces Of TOUGH DINNERWARE!

Other Pieces In The Double-Tough Dinnerware Line—

9" Dinner Plate • 7-oz. Cup and Saucer
15-oz. Bowl • 5-oz. Sauce Dish
6¾" Bread and Butter Plate

Mugs stack for easier handling! And the easy-to-grasp handles just can't break off—they are an integral part of the cups!

A COMPLETE LINE OF TUMBLERS —From 4 Ounces To 12 Ounces— TO MEET EVERY NEED!

Look for the LITTLE GLASS BLOWER trade-mark on the bottom of each tumbler!

Consumer Products Division

Corning Glass Works • Corning, New York

"CORNING," "PYREX," and "Double-Tough" are trade-marks in the U. S. of Corning Glass Works, Corning, N. Y.

He carries on the Jerman tradition

AS a G-E x-ray technical service man, his is a proud heritage. He belongs to a group founded in 1917 by Ed C. Jerman to provide the first organized technical aid to radiologists and their technicians. One of its outstanding contributions was the standardization of radiographic technic. It has also developed such personalities as Glenn Files and "Bob" Mahoney — technical counselors who will long be remembered in x-ray circles.

Available through General Electric's X-Ray Department, Milwaukee 1, Wis., or local district offices, Technical Service is just one example of how you get much more than equipment when you buy G-E x-ray apparatus. It's another reason why —

You can put your confidence in —

GENERAL ELECTRIC

6

of the many extra services you get from General Electric X-Ray

(1) INSTALLATION PLANNING SERVICE . .	Expert layout of your complete x-ray facilities down to the last detail.
(2) TECHNICAL SERVICE	Operative technical experience available on latest technics and procedures.
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(5) MAXISERVICE®	You can *rent* G-E x-ray apparatus. No initial capital outlay, no obsolescence risk.
(6) SUPPLY SERVICE	Extensive local stocks of x-ray accessories and supplies at 68 field offices.

Bring your wall problems to

"WALL CENTER, U.S.A."

We're specialists . . . in wall coverings. That's why the wall covering division of United States Plywood Corporation has come to be called "Wall Center, U. S. A." That's why you will always find, among the job-proven products described and illustrated here, the one "right" application. Here are a few of those applications:

On walls in hotels, schools, hospitals, etc., that must be kept fresh-looking.

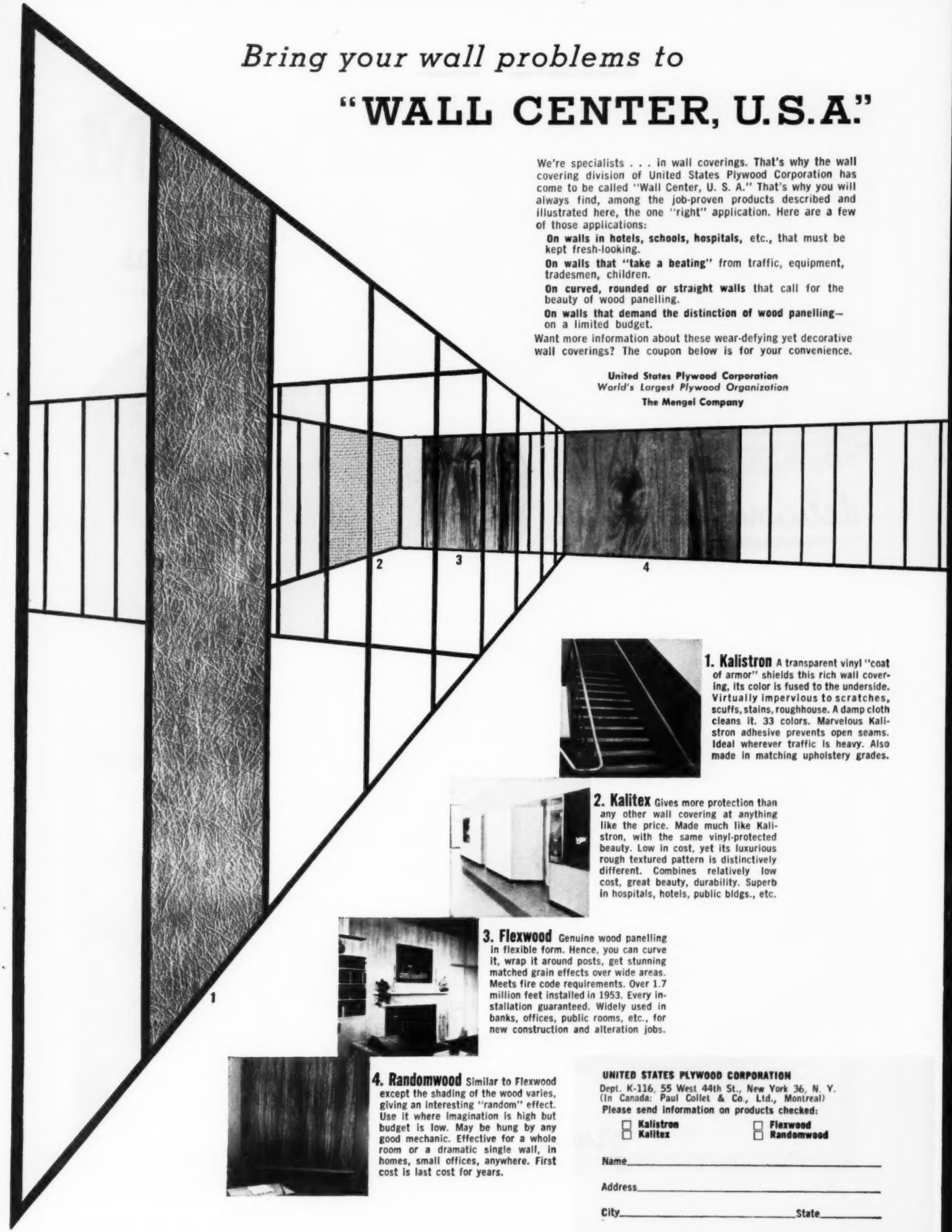
On walls that "take a beating" from traffic, equipment, tradesmen, children.

On curved, rounded or straight walls that call for the beauty of wood panelling.

On walls that demand the distinction of wood panelling— on a limited budget.

Want more information about these wear-defying yet decorative wall coverings? The coupon below is for your convenience.

United States Plywood Corporation
World's Largest Plywood Organization
The Mengel Company



1. Kalistron A transparent vinyl "coat of armor" shields this rich wall covering, its color is fused to the underside. Virtually impervious to scratches, scuffs, stains, roughhouse. A damp cloth cleans it. 33 colors. Marvelous Kalistron adhesive prevents open seams. Ideal wherever traffic is heavy. Also made in matching upholstery grades.

2. Kalitex Gives more protection than any other wall covering at anything like the price. Made much like Kalistron, with the same vinyl-protected beauty. Low in cost, yet its luxurious rough textured pattern is distinctively different. Combines relatively low cost, great beauty, durability. Superb in hospitals, hotels, public bldgs., etc.

3. Flexwood Genuine wood panelling in flexible form. Hence, you can curve it, wrap it around posts, get stunning matched grain effects over wide areas. Meets fire code requirements. Over 1.7 million feet installed in 1953. Every installation guaranteed. Widely used in banks, offices, public rooms, etc., for new construction and alteration jobs.

4. Randomwood Similar to Flexwood except the shading of the wood varies, giving an interesting "random" effect. Use it where imagination is high but budget is low. May be hung by any good mechanic. Effective for a whole room or a dramatic single wall, in homes, small offices, anywhere. First cost is last cost for years.

UNITED STATES PLYWOOD CORPORATION
Dept. K-116, 55 West 44th St., New York 36, N. Y.
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Please send information on products checked:

☐ **Kalistron** ☐ **Flexwood**
☐ **Kalitex** ☐ **Randomwood**

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Address_____

City_____ **State**_____

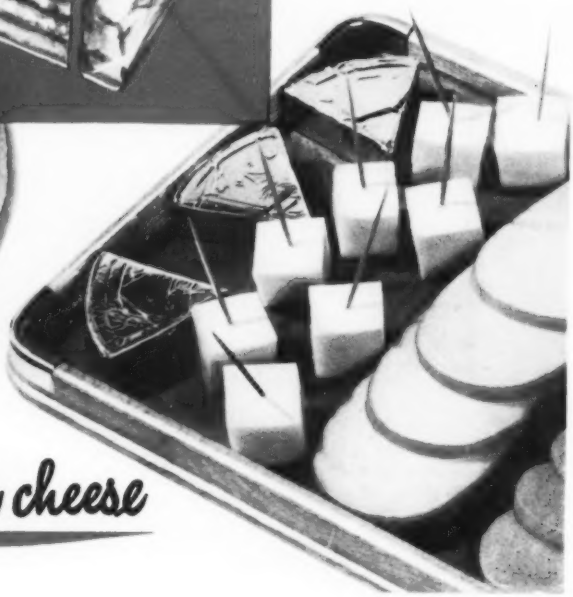
PREMIUM

perfect with soups

delicious with salads

ideal with chili

only 1⅓¢
per serving



grand with cheese

SALTINE CRACKERS

baked by NABISCO

ideal individual cracker service

Treat yourself to greater profits by serving flaky, salty, oven-fresh PREMIUM SALTINE CRACKERS in their handy, moistureproof cellophane packets with the easy opening tear tab. NABISCO is your assurance of top-quality products that you can buy with confidence and serve with pride.

You'll benefit by 6 big advantages when you serve

"NABISCO INDIVIDUALS"

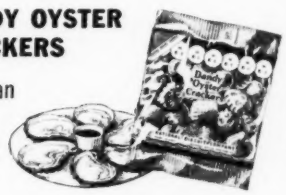
1 Cut food costs
2 Always fresh
3 Easier to handle
4 Eliminate breakage
5 Top quality
6 Exact portion control

Try these other Famous "NABISCO INDIVIDUALS"

FOUNTAIN TREATS
less than 1 3/5¢ per serving

served with ice cream

DANDY OYSTER CRACKERS
less than 2¢ per serving



served with oysters

RITZ CRACKERS
only 1¢ per serving

served with juices

SEND FOR FREE SAMPLES AND BOOKLET

Taste the delicious freshness of the crackers . . . keep the booklet handy, you'll find it's packed with wonderful ideas on how to increase sales and cut food costs.

PRODUCTS OF NATIONAL BISCUIT COMPANY

National Biscuit Co., Dept. 23, 449 W. 14 St., N. Y. 14, N. Y.
Kindly send samples and new booklet "America's Home Favorites"

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Organization.....
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NABISCO


They like it...

Cinnamon-flavored,

ready-mixed form of the new antibiotic

. . . stable 18 months . . . administer any time

It's tasty. It's stable. It's *Pediatric* ERYTHROCIN Suspension—made especially for little patients. Rich in cinnamon flavor, *Pediatric* ERYTHROCIN has a sweet candy-like taste that children really like.

And it works. Against common winter coccal infections. Against pyoderma, erysipelas, and other infectious conditions. Especially advantageous against staphylococci—because of the high incidence of staphylococcal resistance to many other antibiotics and when the patient is allergically sensitive to other antibiotics.

Gastrointestinal disturbances rare. *Pediatric* ERYTHROCIN is specific in action—*less likely to alter normal intestinal flora than most other antibiotics.* No serious side effects reported.

Pediatric ERYTHROCIN comes in 2-fluidounce, pour-lip bottles. *No mixing required.* Can be administered before, after or with meals. Prescribe *Pediatric* ERYTHROCIN. Abbott

pediatric

Erythrocin

TRADE MARK

stearate

(Erythromycin Stearate, Abbott)

Oral Suspension

DOSAGE

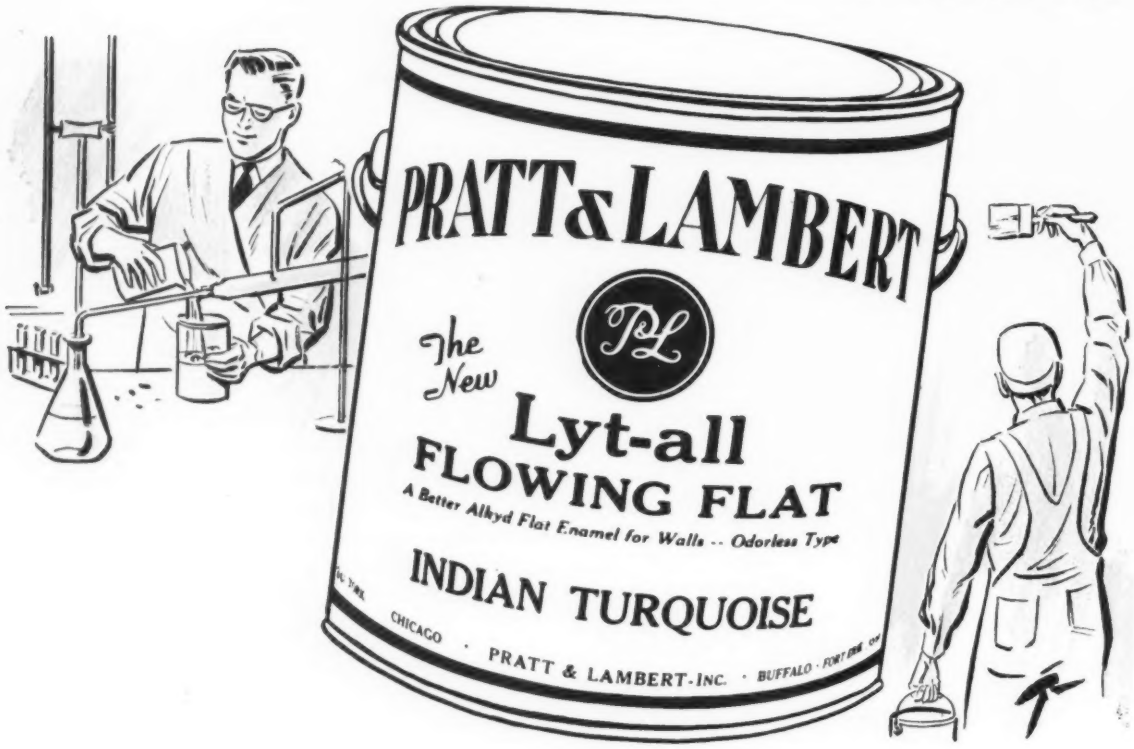
One 5-cc. teaspoonful represents
100 mg. of ERYTHROCIN
25-lb. child—½ teaspoonful
50-lb. child—1 teaspoonful
100-lb. child—2 teaspoonfuls
Every 4 to 6 hours

3-96-54

635 Formulas Were Tested

to Bring Maintenance Executives this Better Alkyd Flat Enamel

for Walls and Trim



To find the formula that would best give you the dependable quality — the durability, scrubbability, ease of application, freedom from painty odor and other desirable properties you want for maintenance painting, 635 formulas were developed and tested, both in the laboratory and on actual jobs, to produce Pratt & Lambert *New* Lyt-all Flowing Flat, white and colors.

Hundreds of hospitals, schools and similar large users have already tried it and reported enthusiastically on their experiences. Here are the reasons:

TRULY SCRUBBABLE — Gives you the economy of more washings between paint jobs.

EASY APPLICATION — Rolls or brushes on without pull and drag — producing an exceptionally-smooth finish without streaks or laps.

EXCELLENT HIDING — One coat usually covers previously-painted surfaces. On new work, two coats give perfect results without priming.

FREE FROM OBJECTIONABLE ODOR — both during painting and afterwards. Use a room as soon as it's dry — a matter of just a few hours.

SUITABLE FOR ANY WALLS AND TRIM — Equally effective on cinder blocks, wood, metal, dry wall, plaster and all similar surfaces — and on adjacent trim of wood or metal.

BEAUTIFUL COLORS — 24 ready-to-use, de luxe, Calibrated colors and white.

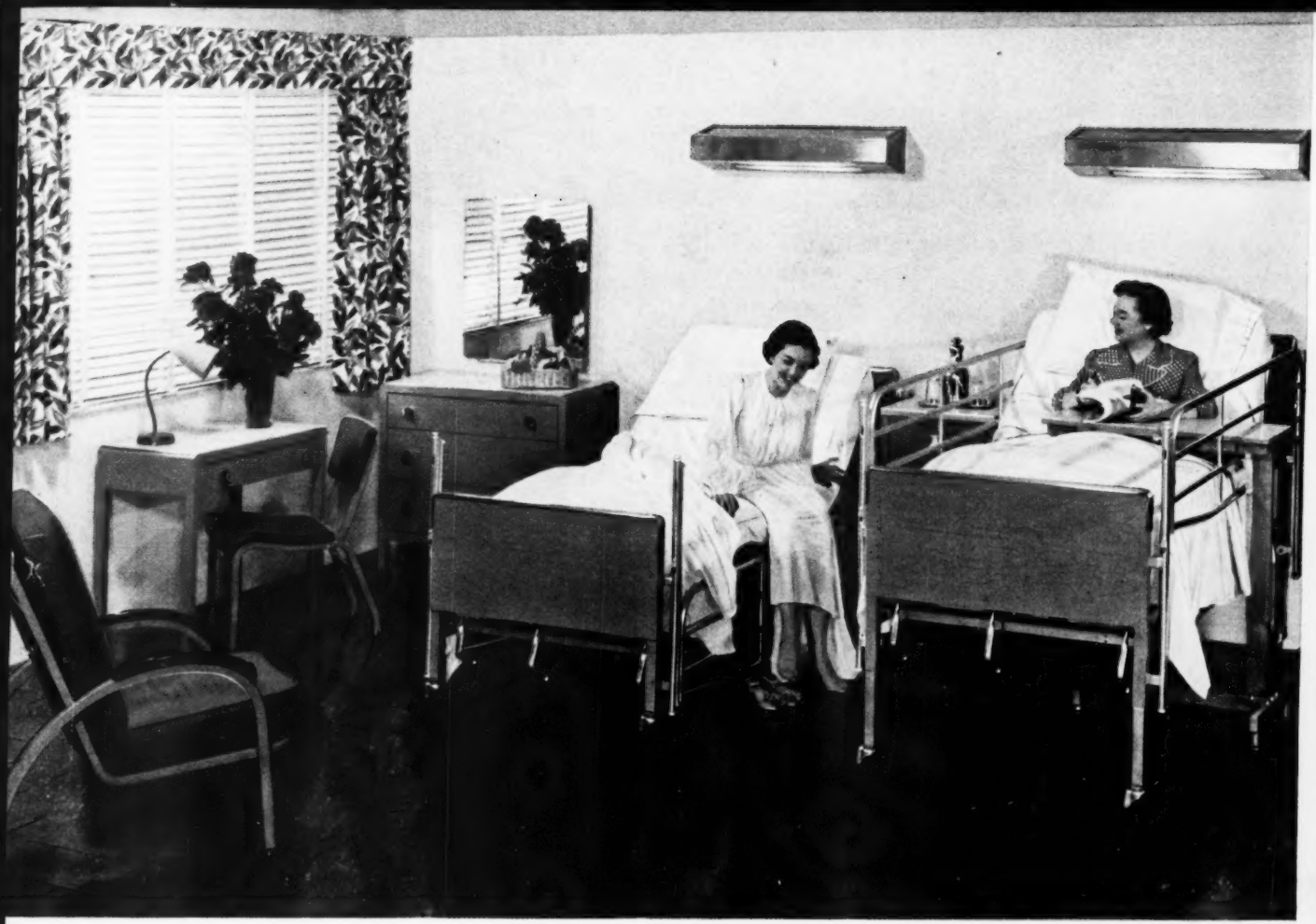
Pratt & Lambert *New* Lyt-all Flowing Flat is *not* a rubber-base or water-thinned paint. It's your better Alkyd Flat Enamel for walls and adjacent trim — the newest product in the line of fine Pratt & Lambert Paints and Varnishes which are the result of 105 years of manufacturing experience and continuous, scientific research.

And as with all Pratt & Lambert products, the covering capacity, long-life and moderate price of *New* Lyt-all Flowing Flat spell true maintenance economy. Try it! You'll like it!

PRATT & LAMBERT-Inc.

A Dependable Name in Paint Since 1849

NEW YORK • BUFFALO • CHICAGO • FORT ERIE, ONT.



LOS ANGELES' FAMOUS

Cedars of Lebanon Hospital

SELECTS SIMMONS...OF COURSE

The concept of a new Maternity and Pediatrics Building for world-famous Cedars of Lebanon Hospital demanded furnishings and equipment that would not only be the last word in efficiency and practicality, but would provide color, warmth and beauty as well. The selection was Simmons—of course.

Quality of workmanship and materials has been a Simmons byword for over 30 years. No other line of hospital equipment can match Simmons for efficiency and versatility—kept constantly up-to-date through ceaseless testing under actual hospital conditions. Yet, as shown above, the color, warmth and styling of Simmons Furniture form a sharp contrast to the cold institutional atmosphere usually associated with the word "hospital."

If you're planning new construction or refurnishing, see your Simmons Dealer, or write the nearest Simmons office for helpful advice.

Room shown above is from the new Maternity and Pediatrics Building, Cedars of Lebanon Hospital, which has been furnished completely by Simmons. Furniture is Simmons "152" Series in Silver Mist. Beds are versatile Simmons Vari-Hite, equipped with 3-crank springs and safety sides.

Contract Division

SIMMONS COMPANY

Display Rooms:
Chicago 54, Merchandise Mart
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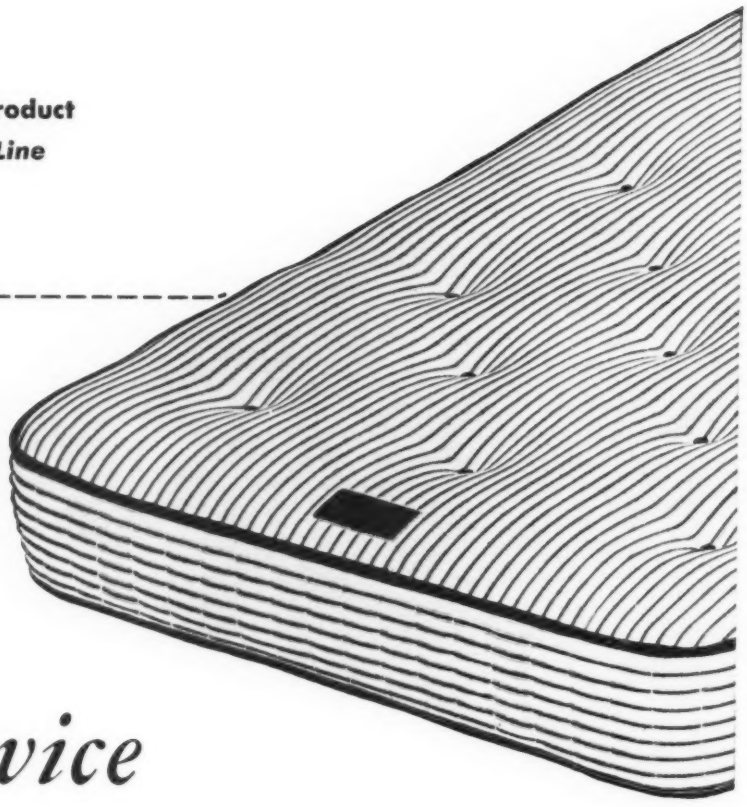
Another hospital-tested product from Simmons *Complete Line*

SIMMONS Furniture



After 17 Years of Service

"CONDITION EXCELLENT"

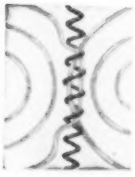
SIMMONS HOSPITAL-BILT (MB-197) MATTRESS

In 1936, University of Wisconsin, Madison, purchased the first of its Hospital-Bilt Mattresses for the University Hospitals. They were put into service at Wisconsin General on gatch-spring beds — one of the toughest tests of a hospital mattress. Since that time they have been in continual use.

Recently, one of these original mattresses was cut open and thoroughly examined. The findings: after 17 years of hard use, none of the coils or knots were broken, there were no signs of rust; condition of the felt, sheeting, and border was excellent.

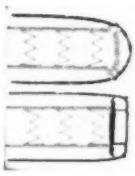
The University Hospitals, with over 900 beds, use Hospital-Bilt Mattresses by Simmons. For low maintenance costs through years of hard service, you can't beat Simmons' durable construction. Get in touch with your Simmons hospital supply dealer today.

years of comfortable service are built into every MB-197



Simmon's offset coil construction permits mattress to flex without stretching or compressing: reduces friction. Offset coil is attached to round top coil, alternately. Hand assembled; helical-tied.

Tempered, innerspring coils of improved type. Coils have silent hinged flexible action.



WRONG! Note sides of mattress bulge due to improper border treatment. RIGHT! Simmons 3-Star *** Crushproof border, with outer coil row attached, eliminates mattress sag.

SIMMONS COMPANY
HOSPITAL DIVISION

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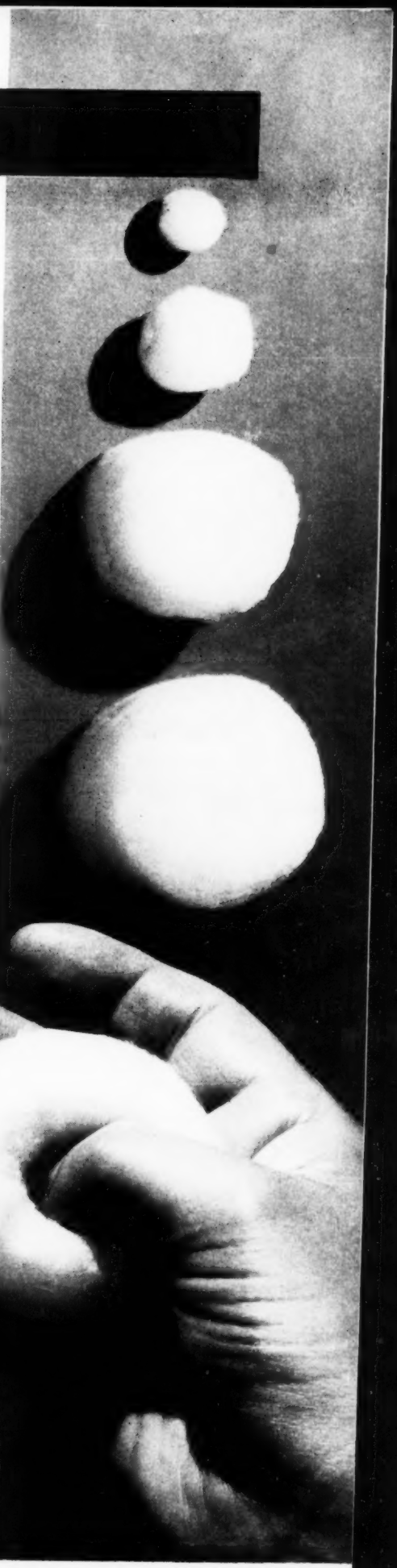
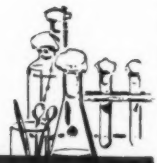


From ENT clinic to the OB ward . . .
all departments find CAROLAB COTTON BALLS
are handy and convenient to use—
completely free of nibs and wispy ends.
They are also an economical substitute
for sponges in many hospital procedures.
The laboratory and dispensary
find that they save time and money.
Cleaning instruments and equipment,
stopping test tubes, bottles and capsule containers,
are all duties which can be speeded up
at lower costs with CAROLAB.



7 reasons why leading hospitals choose CAROLINA COTTON BALLS

1. Uniform in size and shape
2. Firm, compact construction
3. Made of finely spun, selected long staple cotton
4. Highly absorbent
5. Labor-saving—ready for immediate use after sterilization
6. Actually more economical to use than "home-made" cotton balls or other manufactured balls of same high quality
7. Available in 5 standard sizes:

super	2000 per case
special	2000
large	2000
medium	4000
small	8000

special is same size as large but is almost twice as dense

WRITE FOR SAMPLES, INFORMATION, PRICES

manufactured
where grown...

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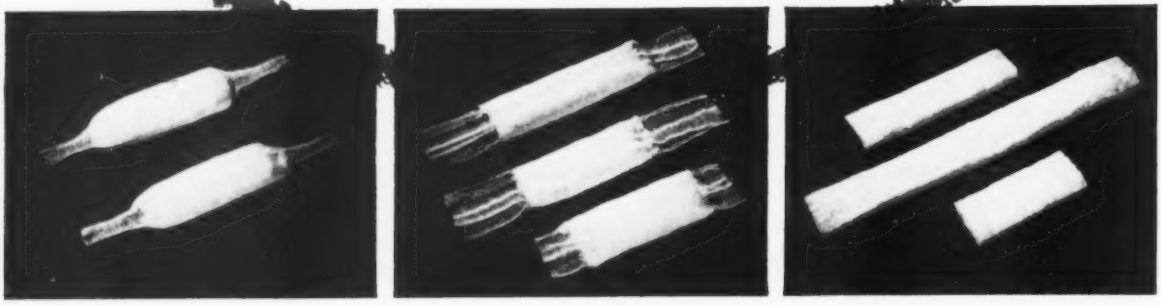
Carolina Absorbent Cotton Co.

(Division of Barnhardt Mfg. Co., Inc.)
CHARLOTTE 1, NORTH CAROLINA

patient comfort *Plus* **hospital economy**

Carolina Sanitary Napkins

● Carolab's *cotton*-filled sanitary pads are made from quality materials as carefully processed and treated as Carolab's famous surgical cotton. They do not shrink or become brittle or discolored when sterilized. Heat actually improves them . . . makes them thicker and fluffier to provide the downy-soft comfort and maximum absorptive qualities so important in surgical and obstetrical cases.



Best OF ALL

Cotton-filled, stockinette covered: a soft but sturdy, tubular-knitted casing which completely encloses the cotton . . . convenient, comfortable—no seams, no overlap. Available in all standard hospital sizes with regular tabs.

Best IN ITS CLASS

Cotton-filled, gauze covered: same fine, soft, absorbent cotton, wrapped in good quality gauze. In all standard hospital sizes with regular tabs; regular size with short tab.

WRITE FOR SAMPLES, INFORMATION, PRICES

Best FOR THE MONEY

Tabless, cotton-filled: gauze covered, most economical of all cotton pads. In three convenient sizes: $3\frac{1}{2}$"x8", $3\frac{1}{2}$"x12", and $3\frac{1}{2}$"x24". **Also available—cellulose-filled:** gauze covered, with tabs—an economical substitute for cotton. Four styles: regular, with short or long tabs; senior, with long tabs; hospital, 12" with long tabs.

CAROLAB
Hospital Supplies

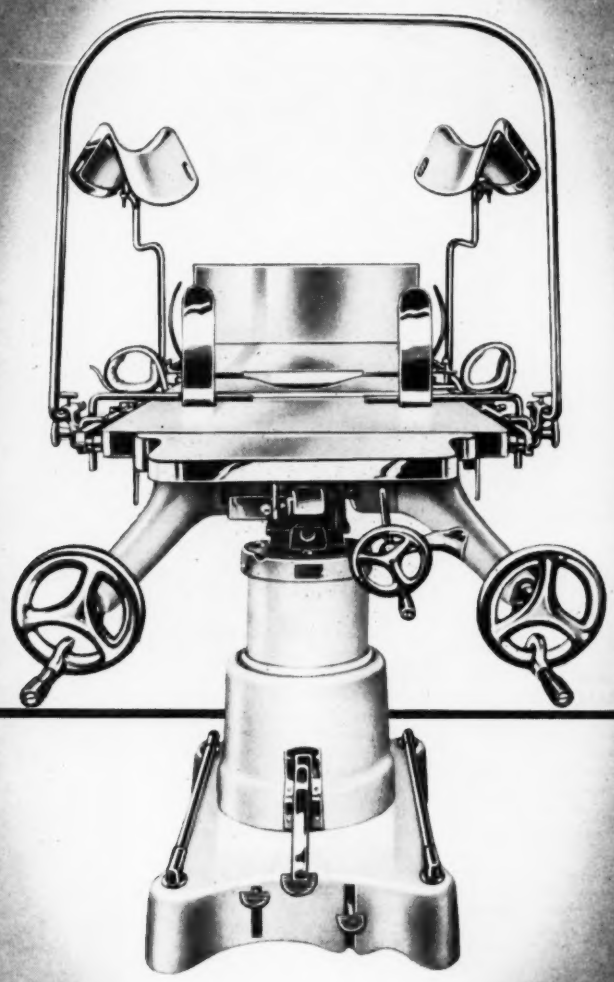
Carolina Absorbent Cotton Company

(Division of Barnhardt Mfg. Co., Inc.)

CHARLOTTE 1, NORTH CAROLINA

TRUE HEAD-END CONTROL the Shampaine S-1502

- all controls face anesthetist
- all controls outside the sterile field
- sides of table free



Full versatility of positioning is accomplished by the seated anesthetist.

The surgical team is never disturbed, and personnel is cut to a minimum.

Compare . . . and you'll choose Shampaine!

Shampaine COMPANY

MANUFACTURERS OF A COMPLETE LINE OF PHYSICIANS' AND HOSPITAL EQUIPMENT

Write For Complete Information

SHAMPAINE COMPANY, DEPT. MH-34
1920 South Jefferson Avenue
St. Louis 4, Missouri

Please send me complete information on the Shampaine S-1502 Major Operating Table

My dealer is.....

Name.....

Address.....

City..... Zone... State.....

Save time and cost

with these tempting California Prune desserts...

Prune Ribbon Dessert

For 25 slices:

1 cup California Prunes—cooked unsweetened, pitted
½ cup brown sugar
50 graham crackers (¾ pound)
1 cup whipping cream
1 tblsp. sugar
1 teasp. vanilla

Chop or mash previously-cooked prunes and cook with brown sugar until consistency of jam. Spread thinly between graham crackers, pressing crackers together to form long loaf. Whip cream until stiff; stir in sugar and vanilla. Frost loaf with whipped cream. Chill in refrigerator overnight. To serve, slice diagonally. Makes 25 slices

Quick Prune Coffee Cake

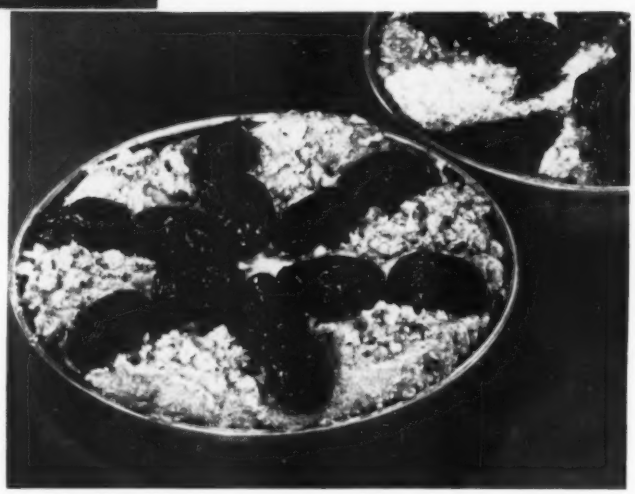
To make 24 servings:

1 quart prepared pancake and waffle flour
1½ cups brown sugar
4 eggs
1½ cups milk
1 cup melted butter or margarine

Topping:

1 cup brown sugar
1 cup all-purpose flour
2 teaspoons cinnamon
⅓ cup soft butter or margarine
1 cup chopped nuts
About 1 pint California Prunes, pitted

Mix together prepared pancake and waffle flour and brown sugar. Beat eggs, and add milk and melted butter. Stir into flour and sugar mixture. Pour batter into 4 well-greased 8-inch round cake pans. Arrange pitted prunes on top of batter. Sprinkle with topping and bake at 375° for 20 to 25 minutes or until done. Cut each cake into 6 pie-shaped wedges. Serve warm. Makes 24 servings. *To make Topping:* Blend together until crumbly, sugar, flour, cinnamon and butter or margarine. Stir in nuts. Sprinkle about ¼ cup topping on each coffee cake



Good eating however you serve 'em!

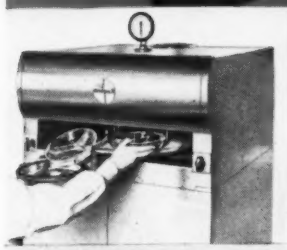
It's simple *and* inexpensive to spark up your quantity-service desserts with luscious California Prunes. Their wholesome *natural* sweetness turns ordinary dishes into special treats. They're always popular, too, for breakfast or as between-meals snacks, right from the package. So rely on California Prunes for low cost, easy storage, simple preparation—and *always* good eating!

FREE! 21 TESTED FORMULAS! Write California Prune Marketing Program, 2 Pine Street, San Francisco 11, California.

PRUNES *the California wonder fruit!*

Serves You RIGHT!

Nothing Protects and Serves Fine Foods like mealpack Exclusive Self-Forming Vacuum Seal



Mealpack Infra-red Dish Heaters *uniformly pre-heat and sterilize each Pyrex Dish ready for packing as the "heat storage battery."*

Mealpack Tables *centralize Container packing and tray assembly at the main kitchen —from 100 to 500 trays per hour.*

Mealpack Tray Carts *act as "portable floor pantries." Hot toast, soups, beverages, ice cream, etc., are added to each tray at serving points.*

All patients enjoy uniformly delicious food because hot foods stay HOT *and cold foods stay* COLD *for hours—even after serving!*

Millions of meals every month are being served the **mealpack** way in hundreds of hospitals, coast to coast! A personal study of nearby installations will prove **mealpack's** exclusive advantages and economies for your food service.

Whether for old or new buildings, additions, or for serving outlying units remote from the main kitchen, a **mealpack** SYSTEM can be custom-fitted to meet your specific needs and conditions. Current installations range from 20 to over 500 beds.

Our Engineering Department is ready to work with you, your dietitian, architects and consultants in determining your requirements, costs and potential savings.

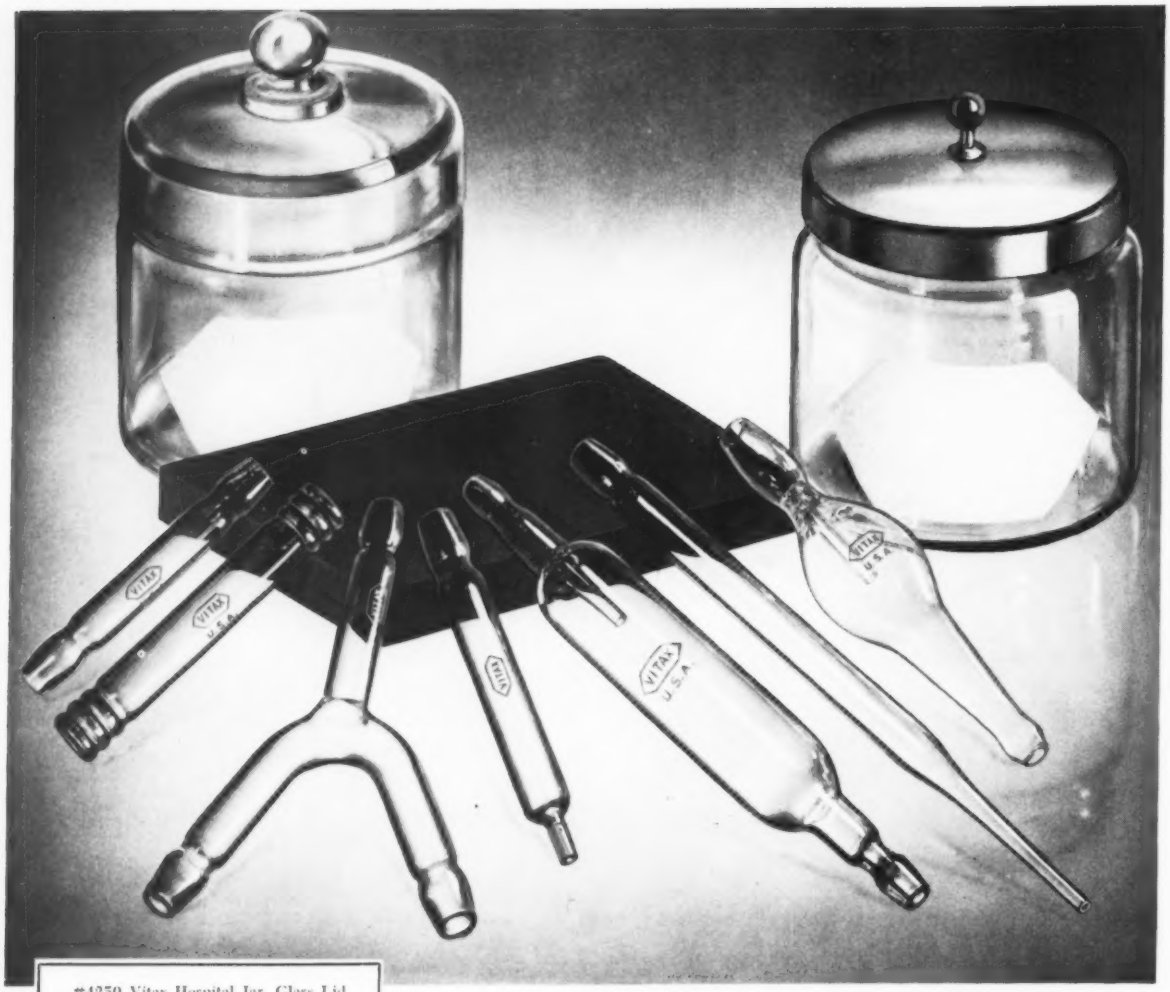
Newest addition to MEALPACK'S *Fleet, the Model HC "***Hostess Cart,***" for auxiliary services. Beautiful, compact, profitable! Literally a combined Snack-Bar, Gift Shop and News-stand "on wheels." Also, doubles for organizing, controlling and serving between-meal nourishments. Ask for* **Leaflet SD-7.**

Write us for the complete **mealpack** *story and for a list of the installations near you*

MEALPACK CORPORATION

A SUBSIDIARY OF AMERICAN HOSPITAL SUPPLY CORPORATION

2014 Ridge Avenue, Evanston, Illinois



#4250 Vitax Hospital Jar, Glass Lid
#4260 Vitax Hospital Jar, Metal Lid (Sand Blast Patch for Marking)
#3640, #3660 Vitax Connecting Tubes Straight • #3690 Connecting Tube, V-shape • #3820 Irrigating Nozzles, Sim's • #3920 Observation Tube #3930 Murphy Saline Tube, with bulb and vent • #3946 Drip Tube

VITAX means safety you can trust . . . plus savings

That every hospital must put safety before economy goes without saying. How to keep costs down in the face of rising costs without sacrificing standards is a real problem.

One way many hundreds of hospital superintendents are meeting this challenge is by specifying Glasco Products' VITAX Glassware.

Here is why

Every piece of Glasco Products' hospital glassware is made of very heavyweight glass. Specially made for hospitals, it is better able to withstand hard treatment in handling, use, and sterilizing.

VITAX glassware is made of glass that withstands corrosive action. It will not discolor or become cloudy after repeated sterilization.

The VITAX trademark appears on each piece of VITAX glassware. Look for it; it is your assurance that you are getting the best in surgical glass. Specify VITAX always and be sure of getting safety . . . plus savings. Consult your hospital supply house.

Free Catalog

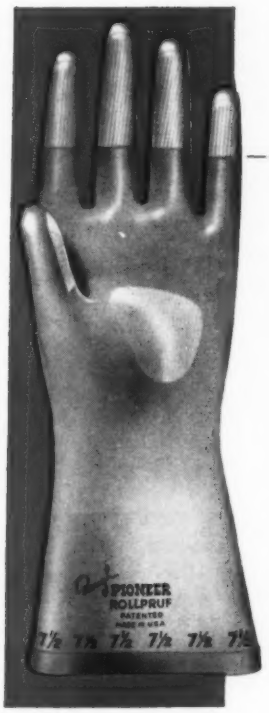
If you don't have our catalog write for a free copy and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

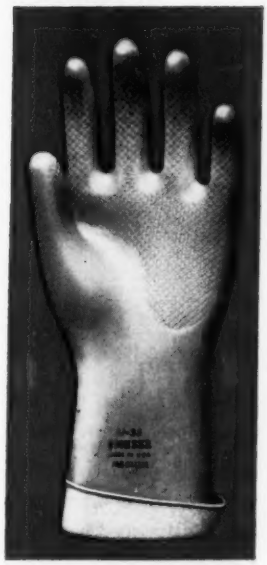
Announcing 2 New PIONEER Gloves

ROLLPRUF *Rough* Surgical Gloves



Extra Sure Grip for Surgeon's Fingers

PIONEER, maker of either-hand Quixam and Obstetrical gloves, Rollpruf and non-allergic neoprene Rollpruf surgical gloves, presents another important advance in surgical glove design—the RP-169R Rollpruf *Rough*. This new PIONEER *rough* texture grip on fingertips and palm provides easier, surer handling of instruments and moist tissue. Extreme sheerness gives utmost fingertip sensitivity—almost barehanded dexterity. PIONEER processed virgin latex retains high strength and elasticity even after extra sterilizations. Rollpruf's beadless flat-banded cuffs cling to surgeons' sleeves—no roll to roll down. Multi-Size markings printed across cuffs speed up glove sorting—save time and expense. Specify PIONEER Rollpruf *Rough* surgical gloves. Available at leading Surgical Supply Houses.



New Flock Lined, Soft —No Clammy Feeling

U-35 Medical Utility Glove...Ideal for non-surgical hospital housekeeping and autopsy...Neoprene—resists oils, acids, caustics, grease, detergents...Short curved fingers—roomy across palm and knuckles for working ease and comfort.

the PIONEER Rubber Company

350 Tiffin Road • Willard, Ohio

Makers of fine surgical gloves for 35 years

FREE – a 3 lb. box

to every Hospital in the United States, Canada and Mexico.

..to prove ALCONOX is a MUST! in

- **TERMINAL STERILIZATION***
- **THE LABORATORY**
- **THE OPERATING ROOM**

Terminal Sterilization in the nursery requires special attention in cleaning baby bottles. For cleaning baby bottles Alconox has proven itself Best and Safest in leading hospitals.

Alconox is also the preferred detergent in operating rooms and laboratories.

See for yourself *how* Alconox cleans Better, Brighter and—for only 2½ cents per gallon. See *why* it outsells all other hospital and laboratory detergents.

Fill out Coupon today

ALCONOX, Inc.

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ALCONOX INC., 61 CORNELISON AVE., JERSEY CITY 4, N. J.

Please send me one 3 lb. can of Alconox, FREE.

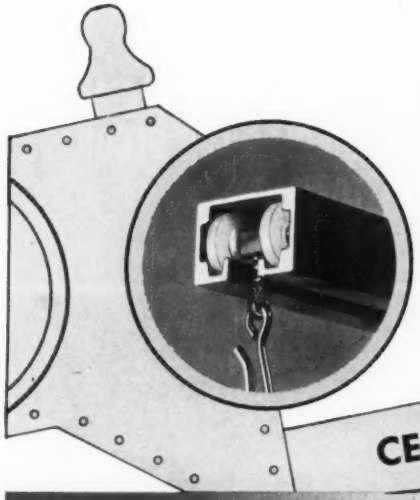
*Please send me a copy of your standard procedure on Terminal Sterilization ☐ other literature ☐

Hospital or Laboratory.....

Address.....City.....State.....

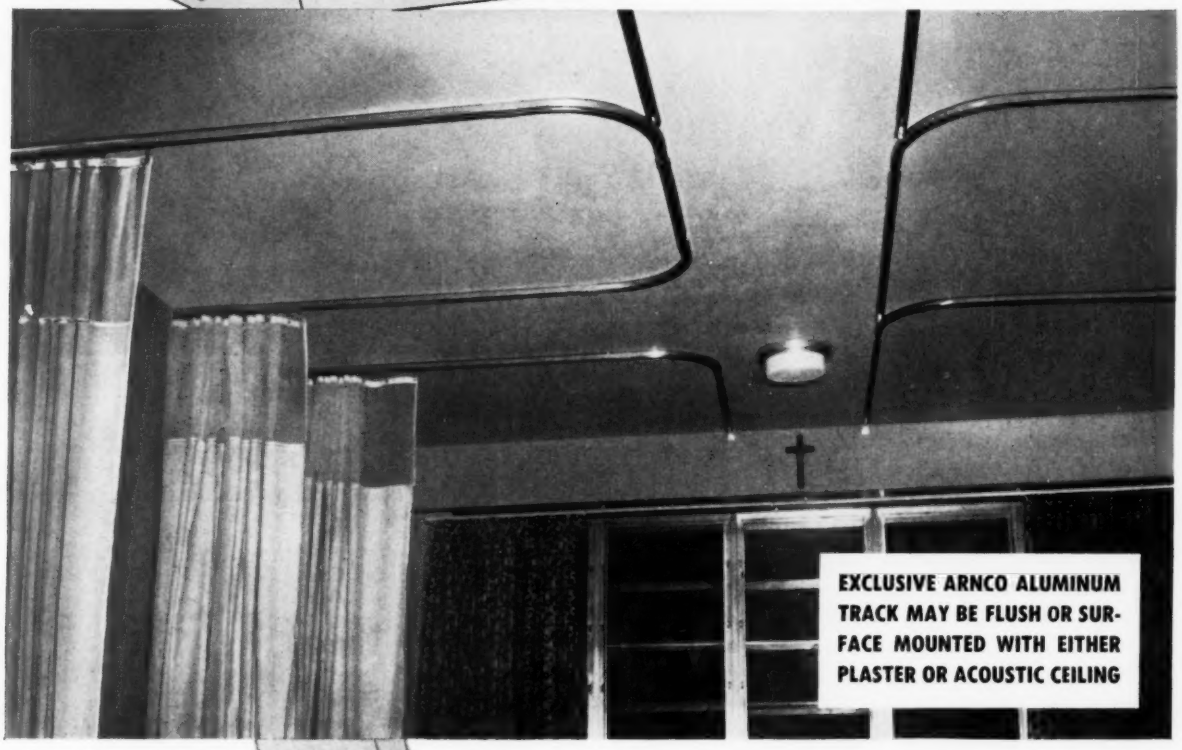
Name.....Dept.....Title.....

This offer expires April 30, 1954.



You're on the RIGHT TRACK with the NEW ARNCO

CEILING TYPE CURTAIN CUBICLE



Completely unobtrusive, these smooth-performing, neat-looking cubicles do not conflict with lighting or wall fixtures — completely eliminate interference with doors or windows.

Sturdily constructed for constant rugged use, ARNCO CUBICLES have a proven record for durability in hundreds of hospitals. Specially designed curtains insure adequate ventilation as well as privacy . . . carrier has plastic wheels on zinc die cast axle . . . plus bead chain for flexibility . . . and rust-proof curtain hook.

The new ARNCO track with *twin-wheel* plastic carrier means smoother operation with less friction. No sliding or binding to interfere with smooth "finger-tip" operation.

To be on the right track in cubicle equipment, switch to ARNCO. Write for details.

ARNCO Cubicles are also available in the suspended type

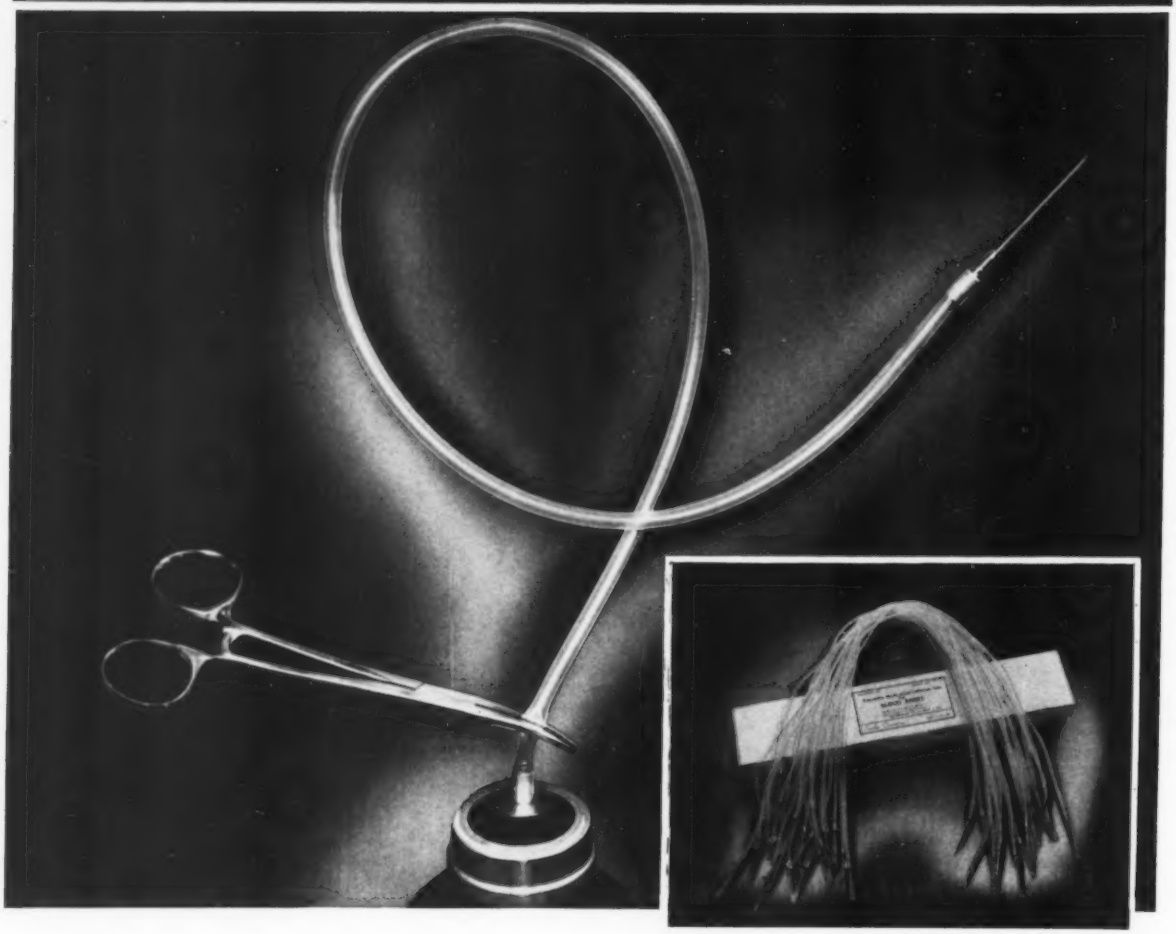
A. R. NELSON CO., INC.

210 East 40th Street • New York 16, N. Y.

NEW! Low Cost Rack sturdily made in non-peeling alumilite finish . . . this easy to install coat and hat rack, or storage shelf finds innumerable uses in hospitals. Write for literature.

Sterilon

The IMPORTANT NAME IN MEDICAL AND HOSPITAL CIRCLES FOR BLOOD TRANSFUSION EQUIPMENT



STERILON'S Contribution to the Nation's Blood Collection Program

You can save your Blood Bank as much as 20¢ on each Expendable Blood Collection Set

Sterilon's D-17-24 Blood Collection Sets (as illustrated) include these features responsible for their growing popularity at Blood Banks:

A saving of as much as 20¢ on each Expendable Set — A Choice of Needle Gauges — Large Free Flowing Tubing — Sterile and Pyrogen Free — Always Ready for Use.

Prepared in accordance with the requirements of the National Institute of Health.

Write for Samples, Prices and Catalog.

STERILON CORPORATION, 500 NORTHLAND AVE., BUFFALO 11, N. Y.

an entirely different angle on antisepsis

Bactericidal...of course! But an antiseptic can't stop with just superficial action. Zephiran chloride penetrates crevices and folds...spreads into wounds... and diffuses over contaminated surfaces. That's why it exerts such pronounced and prolonged germicidal effect.

As a cationic detergent, Zephiran chloride utilizes its wetting and spreading properties to implement gram-negative and gram-positive bactericidal potency.

Supplied as:

Aqueous Solution 1:1000, bottles of 8 oz. and 1 U.S. gallon.

Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U.S. gallon.

Concentrated Aqueous Solution 12.8%, bottles of 4 oz. and 1 U.S. gallon (1 oz. = 1 U.S. gallon 1:1000 solution), must be diluted.

Zephiran, trademark reg. U.S. & Canada, brand of benzalkonium chloride (refined)

ZEPHIRAN® chloride

for antisepsis with finesse

WINTHROP

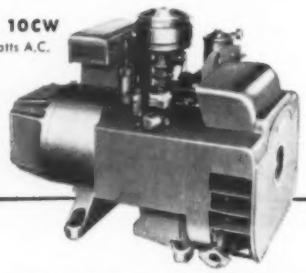
Winthrop-Stearns Inc. • New York 18, N. Y. • Windsor, Ont.

Rate Your Hospital on Standby Power Protection

Standby Power Check Chart for Essential Services and Equipment

	Protected	Not Protected
• Operating Room	☐	☐
• Delivery Room	☐	☐
• Hall and Stair Lighting	☐	☐
• X-Ray Equipment	☐	☐
• Heating System	☐	☐
• Elevators	☐	☐
• Ventilation	☐	☐
• Communications	☐	☐
• Respirators	☐	☐

MODEL 10CW
10,000 watts A.C.



WHAT WILL COMPLETE PROTECTION COST?

Onan's wide range of sizes and models . . . from 1,000 to 50,000 watts . . . permits you to choose the plant that fits *your* capacity requirements *exactly* . . . keeps cost in line with the need. Let us know what equipment must be operated by emergency electricity; we will recommend the size plant you need and estimate the cost.

MODEL 25HN
25,000 watts A.C.

ONAN Electric Plants guard all essential services

If the check-chart above shows standby power for operating and delivery rooms *only*, your hospital may be inadequately protected. Interruption of *any* important hospital service because equipment can't be operated, may endanger lives. Property too may suffer damage.

Onan Emergency Electric Plants, available in sizes up to 50,000 watts, have the capacity to operate whatever you decide is essential . . . elevator, automatic heating system, ventilators, X-ray machines, communications, lighting and other equipment. All Onan standby units can be equipped with controls which start the electric plant automatically when power is interrupted and stop it when power is restored.

Onan ELECTRIC PLANTS

Write for special folder on standby electric power for hospitals

D. W. ONAN & SONS INC.

4940 University Avenue S. E. • Minneapolis 14, Minnesota

GOMCO®

announces

an important new aid to chest surgery

No. 766
THORACIC THERMOTIC DRAINAGE PUMP

Developed to meet rigid standards of chest surgeons, the new Gomco No. 766 Thermotic Thoracic Pump provides constant, gentle intrapleural suction to re-inflate the lungs immediately following operation, and to help maintain inflation during the succeeding crucial forty-eight hours. Suction is within the established safe range (0 to 25 cm. of water) to prevent hemorrhage, yet volume is high enough to handle cases where leakage is present. Silent, attention-free and completely dependable, the 766 is a valuable post-operative aid to the chest surgeon. Operates on 115 Volts, 60 Cycle, only. Your dealer will be happy to give you any further information you may desire. Why not call him or write us?

GOMCO EQUIPMENT

GOMCO SURGICAL MANUFACTURING CORP.

824-H E. FERRY STREET, BUFFALO, NEW YORK

For High-Production, Low-Cost Flatwork Ironing

mechanize with American!

Today, with labor short and labor costs up, more hospitals are "Mechanizing with American"—to insure ample supply of fresh linens at all times, and to gain the service and cost advantages that only American equipment offers.

With American Mechanized Flatwork Ironing, automatic equipment replaces costly labor. Flatwork is mechanically conditioned and conveyed to the ironers, then mechanically folded as it comes from the ironers. This means—

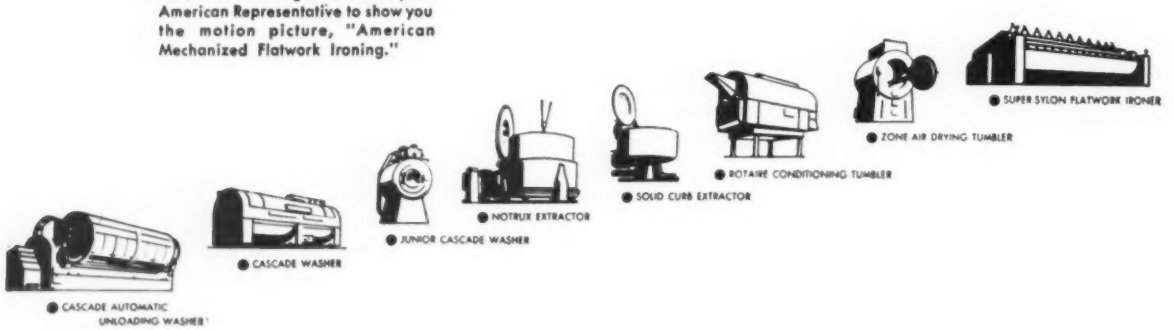
REDUCED LABOR: Operations of trucking, shake-out and preparation are reduced. Manual work of folding and stacking is replaced by automatic equipment.

HIGHER PRODUCTION: With fewer operators, your laundry turns out more work—of better quality—every hour.

COST SAVINGS: Labor savings, increased production and savings in floor space soon pay for your American Mechanization Program.

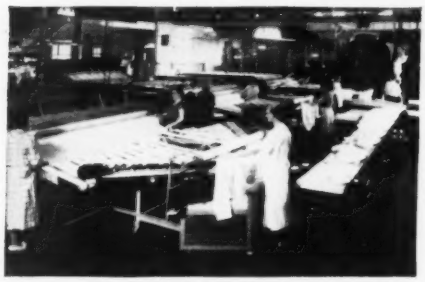
Plan now to "Mechanize with American" . . . step by step, or with a complete installation. Get rid of labor "headaches" and high costs. More hospitals use quality-engineered, quality-built American Laundry Equipment than any other kind, because it is dependable and costs less to operate. Call in your American Laundry Consultant for all the facts!

For the complete story of higher ironing production and lower costs —ask for illustrated book, #AD 714-502, "American Mechanized Flatwork Ironing." Or ask your American Representative to show you the motion picture, "American Mechanized Flatwork Ironing."

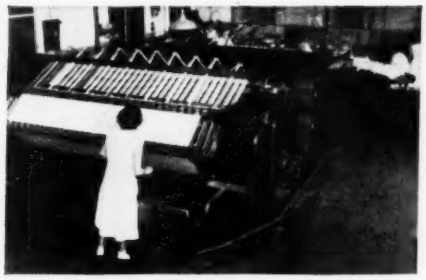


● CASCADE AUTOMATIC UNLOADING WASHER
● CASCADE WASHER
● JUNIOR CASCADE WASHER
● NOTRUX EXTRACTOR
● SOLID CURB EXTRACTOR
● ROTAIRE CONDITIONING TUMBLER
● ZONE AIR DRYING TUMBLER
● SUPER SYLON FLATWORK IRONER

AMERICAN MECHANIZED EQUIPMENT FOR large-piece flatwork:



Conveyor-fed 48x84" Rotaire Continuous Conditioning Tumbler (right) mechanically prepares flatwork so that it is warm, with moisture evenly distributed for faster, better ironing. Conveyors deliver conditioned large pieces to Sager Spreaders which automatically open up work for feeding operators at two ironers in foreground. Other conveyors deliver conditioned small pieces to feeders at third ironer.



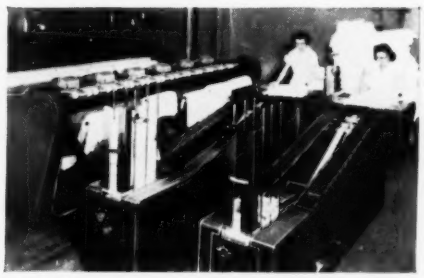
Trumatic Folder automatically quarterfolds large flatwork from ironer with only one receiving operator needed to crossfold and stack linens. Trumatic is available in four models, single and double lane, for folding all large linens, also pillow cases, towels and other small flatwork.

COMPLETE MECHANIZATION
(Large-piece flatwork):

- 48x84" Rotaire Conditioning Tumbler
- Conveyors
- Sager Spreader
- Trumatic Folder

AMERICAN MECHANIZED EQUIPMENT FOR small-piece flatwork:

34x72" Rotaire Continuous Conditioning Tumbler, for small flatwork exclusively, delivers steady flow of properly conditioned pieces via conveyors directly to feeders at ironer. Eliminates costly manual shakeout and transporting of small flatwork. Saves floor space.

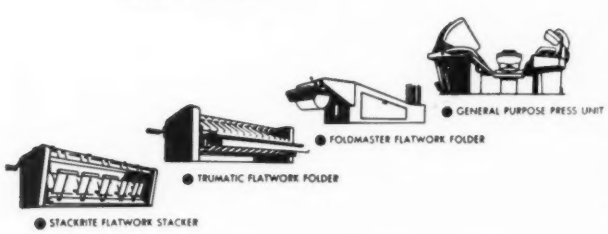


Stackrite Stacker (left) automatically stacks small flat pieces in individual lanes as they come from ironer—eliminates need of receiving crew. Foldmaster Folders (foreground) automatically fold small pieces, stacking them in neat, square piles counted off into lots of 10, 25 or 50 pieces. By merely setting lever, Foldmaster can be adjusted for folding pieces which are 11" to 23" wide and up to 42" long, and fold them to any width between 5½" and 8½".

COMPLETE MECHANIZATION
(Small-piece flatwork):

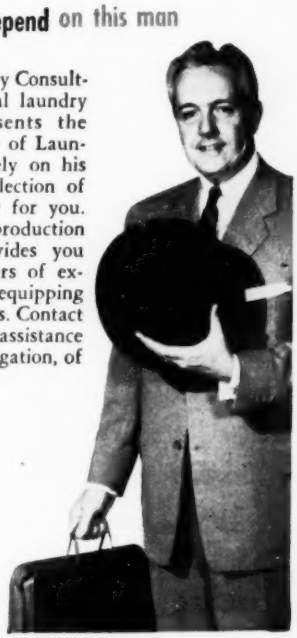
- 34x72" Conditioning Tumbler
- Conveyors
- Automatic Feeding and Spreading Device
- Stackrite Stacker
- Foldmaster Folder

There isn't a single hospital laundering equipment need that can't be served by American!



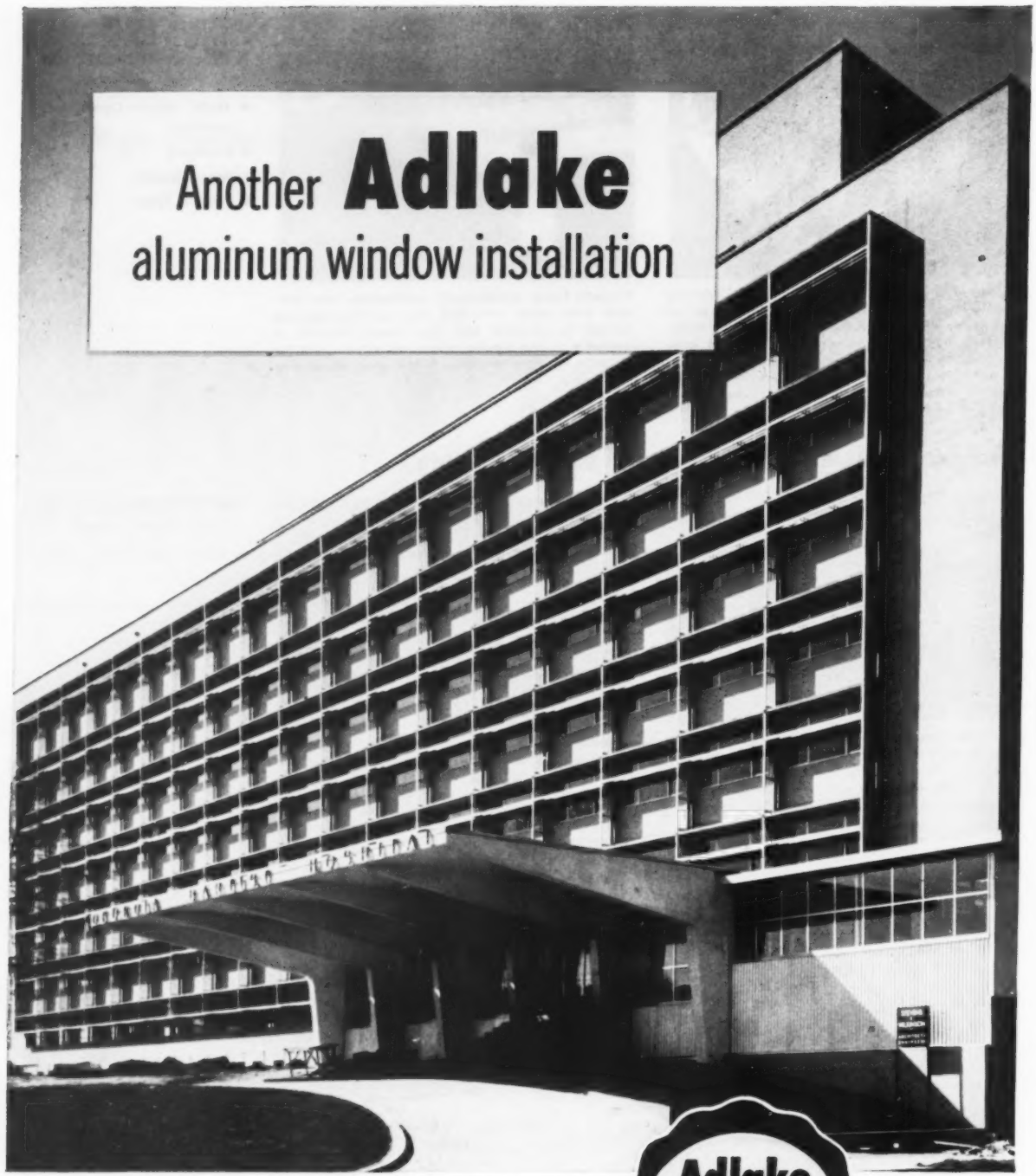
You can depend on this man

He's your American Laundry Consultant, well-trained in hospital laundry operation. As he represents the World's most *complete line* of Laundry Equipment, you can rely on his unbiased advice in your selection of equipment that's *just right* for you. He can help solve your production problems because he provides you with American's many years of experience in planning and equipping hospital laundry departments. Contact American for his specialized assistance at any time . . . without obligation, of course.



The
AMERICAN
LAUNDRY MACHINERY CO. **CINCINNATI 12, OHIO**

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment



Georgia Baptist Hospital—Atlanta, Georgia; Stevens & Wilkinson, Inc.—Architects; Henry C. Beck—Contractor.

- **Minimum air infiltration**
- **Finger-tip control**
- **No painting or maintenance**
- **No warp, rot, rattle, stick or swell**
- **Wool woven-pile weather stripping and exclusive patented serrated guides**

Adlake
PROVEN QUALITY WINDOW

This window meets or exceeds all quality industry specifications for aluminum windows.
THE Adams & Westlake COMPANY
Elkhart, Indiana

97th year of serving the transportation and building industries

The Adams & Westlake Company

Established 1857 • ELKHART, INDIANA • Chicago • New York

Also Manufacturers of ADLAKE Mercury Relays and ADLAKE Equipment for the Transportation Industry

Small Hospital Questions

Staffing Emergency Room

Question: In recent years, a change in the population and character of the area surrounding our hospital has increased the number of accident cases we are called on to serve. We have no interns or residents and I feel we have not yet worked out a satisfactory method of staffing our emergency room. Do you have any suggestions?—B.H., Calif.

ANSWER: We presume you have been using the usual method of "rotating" the emergency service assignment, a few days or a week or more at a time, among members of the attending medical staff. Of course, when staff members on emergency service do not respond promptly when called, this method is unsatisfactory, and either the emergency assignment must be limited to doctors who can be quickly available during their period of service, or some means must be found to keep the hospital satisfactorily "covered" other than by staff rotation. In many hospitals, a paid house officer (who of course has other duties besides emergency service) has been the answer; in others, young physicians moving into the community have been glad to accept the emergency assignment, with the hospital providing a minimum guarantee and the physician collecting private fees from patients who can pay.

Help for Head Nurses

Question: Because of the continuing shortage of nursing personnel, especially in the more responsible positions, we have been compelled several times to call on staff nurses to become head nurses overnight. What can we do to help these nurses meet their new responsibilities?—E.B., Fla.

ANSWER: Ideally, these nurses should be detached from duty to take a refresher course and supervisory training. Since this is rarely possible, however, and was clearly not feasible in the situation described, we would suggest writing to the nearest college or university asking about training aids for supervisory responsibilities. Several state nurses' associations have developed institute programs for head nurses and these, too, should be investigated. Some community hospitals have sought and found assistance among the personnel and industrial relations executives of local industry—a possibility that may be explored through members of the hospital board. Certainly, these nurses should have the new publication of the National League for Nursing, "The Head Nurse at Work," and other texts and manuals dealing with these responsibilities.

Doctors vs. Records

Question: One of the busiest and ablest doctors on our staff takes the view that "most medical records are nonsense anyway," and, as a result, all our efforts to keep patients' charts up to date are simply wasted. As a young administrator I am interested in obtaining accreditation for our hospital if possible; do you have any suggestions as to how we might approach this problem?—C.W.T., Idaho.

ANSWER: This would appear to be a long-term, uphill struggle. If members of the medical staff are not interested in having the hospital accredited, possibly the problem should be approached through the board of trustees, with a carefully planned program of educating trustees in the value to the community of accreditation as a guarantee of high standards of hospital and medical care. Once trustees, or at any rate a working "core" of board members, is convinced of the value of accreditation, the staff problem can be tackled again, with greater support and authority. Eventually, some kind of "showdown" with members of the staff whose records are delinquent may be called for, but it would appear that you are not yet near the point at which any such showdown would be likely to produce the desired result. If you have not already done so, we would suggest that you write to the Joint Commission on Accreditation of Hospitals for information about the accreditation program.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Insurance Claims

Question: Several patients have complained to us recently that their insurance companies have rejected claims "because of information they got from the hospital." What satisfactory answer can we give these patients to avoid bad feeling toward the hospital?—E.S., Ill.

ANSWER: Most fair-minded people will understand that you must file accurate and truthful information with insurance carriers, within the law, as a necessary factor in the whole process of hospitalization insurance. Given an opportunity to make such an explanation, this should suffice in all but a few cases. There will always be one or two disgruntled patients who will be satisfied by nothing short of payment of the claim, and probably nothing can be done about them.

Credit Cards for Patients

Question: We are thinking of establishing a "credit card" system so that patients with established credit, but without hospitalization insurance, can be identified quickly at the time of admission and need not be asked for a cash deposit. Have hospitals elsewhere used any such system?—B.D.S., Ill.

ANSWER: Yes. For example, member hospitals in the Rochester, N.Y., Regional Hospital Council are using a hospital identification card that is issued to hospital board and staff members, executive employes, "friends of the hospital with known good credit, and the general public by application." Identification card applicants are checked by the credit bureau, the same as any charge account or installment account applicant at a department store would be checked, it is explained. The card entitles the bearer or any member of his family to charge outpatient services and to be admitted to any of the issuing hospitals without advance payment, with the understanding that suitable financial arrangements will be made within 48 hours following admission.

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H-B OUT IN FRONT

Through a process that might be called leap-frogging, legislation to broaden the Hill-Burton hospital construction program is far out ahead of other bills in the health fields and is pointed directly toward enactment. It appears now that only development of a domestic or international crisis could prevent its passage at this session.

The bill would amend the Hill-Burton law so that this mechanism could be used to pass federal money on to states to help in the construction of diagnostic and treatment centers, chronic disease hospitals, rehabilitation facilities and nursing homes. Even under present H-B law, most of these facilities would be eligible. The new law would clear up any question, at the same time advertising the Administration's goal of building more diversified health projects.

The ease and speed with which this legislation was moved ahead on the congressional schedule is a tribute to something; perhaps to high level administration strategy of concentrating attention, and opposition, on a reinsurance plan at the outset of the session. While proponents and opponents of reinsurance were well entangled in argument, the new Hill-Burton plan was shifted into high gear.

Here is the chronology:

1. Late in the fall the Administration became interested in the reinsurance principle, and this was mentioned in the President's January messages to Congress.

2. **The Hill-Burton** amendment also was mentioned by the President, but at the outset attracted little attention.

3. **As far back** as last summer the House interstate and foreign commerce committee, under the chairmanship of Rep. Charles Wolverton, started a study of health problems.

4. **In January,** in revived hearings, the committee turned the spotlight on reinsurance; almost every witness was asked by Mr. Wolverton to take a stand on reinsurance. With few exceptions, witnesses opposed the idea or asked for a chance to study the Administration's proposal, which had not been offered in the form of a bill.

5. **In mid-February,** the Wolverton committee closed off its study of voluntary health plans and reinsurance, at least for the time, and switched to the Hill-Burton bill, which had been introduced by Mr. Wolverton shortly before.

6. **The committee** devoted only two days to a hearing on the Hill-Burton project, ending the study even before the American Hospital Association had had a chance to testify.

7. **Without more ado,** the committee reported out the bill and asked the House to pass it.

8. **Without waiting for House passage,** the Senate health subcommittee announced it would hold hearings on H-B expansion; before it is a bill offered by Sen. Alexander Smith (R.-N.J.), chairman of the parent labor and public welfare committee. Thus, fast Senate action also is just about assured.

ADMINISTRATION'S PROGRAM

Various Administration spokesmen, including Secretary Hobby and Surgeon General Leonard Scheele, have given this outline of the country's hospital construction problem and these suggestions for its solution:

Under H-B law, 106,000 hospital beds have been constructed. The Administration thinks there has been too much emphasis on general medical and surgical beds, and not enough on mental (11,000), chronic (3000), and tuberculosis (6000).

The proposed amendment calls for $20 million a year for three years for chronic disease hospitals. This, with $16 million in state and local funds, would build just under 3000 chronic disease beds per year. The operating cost would be much less than the cost of servicing short-term general hospital beds.

The bill also would allow $20 million annually for diagnostic or treatment facilities, to be about matched by the state or local community. There is no estimate of the number of such facilities this total would finance, but Mrs. Hobby comments: "Because such facilities are designed to serve ambulatory or outpatients, and to emphasize prevention, they help to decrease the need for (expensive) inpatient care. . . . There is no reason why many communities which have no hospitals could not build and maintain modern diagnostic and treatment centers."

A total of 10 million U.S. dollars would be earmarked annually for nursing homes. Matched with 8 million state and local dollars, they would account for 2250 nursing home beds per year. The same money would purchase about half as many general hospital beds. It would cost only about one-third as much to operate the nursing home beds as general hospital beds.

The $10 million federal money made available annually for rehabilitation facilities would be matched by $8 million from state and local sources. The extra facilities could care for about 12,000 more persons each year. Ultimately, the federal government hopes to rehabilitate 200,000 persons, in contrast to the 60,000 cared for now.

RESPONSE TO PROGRAM

Although the program would cost the federal treasury the impressive sum of $182 million over the three years ($2 million for planning), it so far has not been subjected to any rough treatment on Capitol Hill. In fact, only one witness flatly opposed the bill. He was a spokesman for the American Association of Nursing Homes, whose members could not qualify for benefits as nonprofit. Among other things, this association questions why a "private enterprise" Administration wants to set up "unfair competition" for private industry in one particular segment of the economy.

The American Medical Association, while supporting the bill, asked that some changes be made and some safeguards written into the law.

Labor spokesmen, the National Rehabilitation Association, and the American Association for the Blind are behind the legislation.

Executive Director George Bugbee of the American Hospital Association, in a letter to the committee, poses a number of questions, such as:

In view of the present shortage of local maintenance funds for many hospitals, is it wise to assume that new and additional projects could be supported?

Should diagnostic facilities be separated from regular hospitals? (A question also raised by the A.M.A.)

Why categorize funds into five divisions? Couldn't program be initiated under present H-B law, with minor amendments and new regulations, so all types of facilities could draw on a common fund?

Mr. Bugbee's letter was in no sense opposition to the program; it merely raised a number of technical questions for the committee staff to look into.

REINSURANCE

Meanwhile, the Administration's reinsurance plan, so popular at the outset of the session, came to just about a dead stop. Why? Probably because the very groups that would have to make it work told Mr. Wolverton they were opposed, critical or skeptical.

Like the American Medical Association, the American Hospital Association wasn't ready to say Yes and it wasn't ready to say No until it had a chance to look over the actual bill. William S. McNary, chairman of A.H.A.'s Council on Government Relations, held to this view despite close questioning by Mr. Wolverton. Regarding the provision of catastrophic care, one of the objectives of federal reinsurance, Mr. McNary observed that he thought the Blue Cross plans were making good progress in this direction. Regarding care for the indigent and medically indigent, he told Mr. Wolverton: "The association believes that, if local and state governments extend their appropriations to the limit of their capacities for financing of such care, there will be limited need for assistance from the federal government."

Mr. Wolverton repeatedly criticized the American Medical Association for its general attitude and its particular policy toward reinsurance. But Dr. Walter Martin, A.M.A. president-elect and its witness, patiently explained each time that the association wasn't buying a pig in a poke.

Dr. Charles G. Hayden of Boston, representing the Blue Shield Commission, blew cold in these words: "An outstanding characteristic of Blue Shield plans is their ability to stand on their own feet financially. It is partly for this reason that they do not look with favor upon any suggestion that their benefit structure or method of operation be subsidized."

E. A. vanSteenwyck of Philadelphia, speaking for Blue Cross, while granting that he didn't see how a federal reinsurance plan could help associations, did give Mr. Wolverton some reason for encouragement. He said a federal reinsurance corporation, set up on an experimental basis, might help local plans to see how far they could go in providing hospital care during unemployment and in offering castastrophic coverage.

George Bugbee Resigns From A.H.A. to Become Health Foundation President

George P. Bugbee

CHICAGO. — George P. Bugbee, since 1943 executive director of the American Hospital Association, has resigned to accept an appointment as president of the Health Information Foundation, it was announced here March 1. Mr. Bugbee will succeed the late Adm. W. H. P. Blandy, president of the Foundation since it was organized five years ago, who died last month.

Prior to his appointment as executive secretary of the American Hospital Association in March 1943, Mr. Bugbee was superintendent of Cleveland City Hospital, a position he held for five years. A graduate of the University of Michigan, he was a member of the business staff of the University Hospital at Ann Arbor as credit manager, office manager and assistant director from 1926 to 1938.

As chief executive of the American Hospital Association, Mr. Bugbee directed the association's program through years of greatly expanded service to hospitals, including the establishment of its Washington Service Bureau, organization of trustee and women's auxiliary services, and expansion of publication, institute, and other services to member hospitals. Institutional and individual membership of the association has grown rapidly during the period of his administration, as has public recognition and acceptance of the association as an influence in the health field. Other programs established during Mr. Bugbee's administration brought the association into close contact and cooperation with allied organizations such as the American Medical Association, American Nurses' Association, American College of Surgeons, and others.

As president of the Health Information Foundation, Mr. Bugbee will direct a program which he helped to organize in 1949. With the support of leading pharmaceutical manufacturers, the Foundation investigates and studies all phases of medical and hospital care throughout the United States. The Foundation has recently published an extensive report covering studies of medical costs and health insurance protection conducted last year.

In accepting his new appointment, Mr. Bugbee told The MODERN HOSPITAL, he feels he is carrying forward the work he has been engaged in for the last 10 years, in an important and promising direction. He will assume his duties as president of the Foundation, with headquarters in New York, on May 1.

A committee of the board of trustees of the American Hospital Association has been appointed to screen candidates for appointment as Mr. Bugbee's successor, he said. The committee will hold an initial meeting in Chicago March 14, it was reported.

The Modern Hospital
MARCH 1954

LOOKING AROUND

Case History

FROM a distance, it would appear that a hospital's obligation to care for the sick and a public official's obligation to serve the electorate and a newspaper's obligation to inform its readers were similar things, and that the government, the press and the hospital should exist amicably side by side in a society devoted to the welfare of the individual. At close range, however, it develops that the hospital has to stay solvent, the official has to get elected, and the newspaper has to sell papers; these stern facts of life can make the relationship uneasy, if not actually painful. At times, it becomes impossible for each to do what it has to do without hurting somebody. This was the lesson, or one of the lessons, that emerged from the Case of the Woodlawn Hospital in Chicago last month.

The facts of the Case are familiar. A five-month-old baby, Laura Lingo, was brought to the hospital suffering from burns sustained when a vaporizer being used to treat the baby's cold was upset in its home. The baby was given emergency treatment by an intern, Dr. Hans Jaeger. When it developed that the mother would be unable to pay for the baby's hospital care at Woodlawn, hospital officials suggested it be transferred to the Cook County Hospital, where free treatment is available. The baby was taken by the mother to Cook County, where, fourteen hours after admission, it died. No autopsy was performed, and the precise cause of death remained at issue throughout the controversy that raged among hospital and public officials, and in the newspapers, during the ensuing weeks.

The controversy was touched off when the grief-stricken mother, lashing out at cruel circumstance, charged that the baby had died because she didn't have $100 to pay as a deposit for private care at Woodlawn Hospital. Here was the kind of story the newspapers love, a story of Little People pitted against Authority. Furthermore, it was a story with none of the unfortunate overtones that can sometimes be heard when Authority is a department store, or a packing house, or a steel mill. The story made page one.

Hospital people, at Woodlawn and elsewhere, resented the implication of the story, which, without really distorting the facts, left readers with the impression that the hospital emergency service was operated on the basis of "your money or your life." Speaking carefully on behalf of hospitals, James Gersonde of the Chicago Hospital Council explained why hospitals, as a matter of financial necessity, must minimize losses by having indigent patients moved to Cook County as soon as the medical emergency permits it. That story appeared on page eight.

The Case was now made to order for public officials to get into the act; this was a heaven-sent opportunity to pursue Public Duty and Personal Publicity at one stride. Buckling on their armor, and glancing sideways to make certain the reporters and photographers were comfortable, President Herman N. Bundesen of the Chicago Board of Health and Cook County Coroner Walter E. McCarron declared that they were going to conduct investigations of hospital emergency services to determine whether hospitals were complying with laws governing treatment of emergency cases. Mayor Martin Kennelly appointed a special committee to "spot check" Chicago hospitals on their handling of emergencies. Dr. Bundesen called a meeting of hospital administrators and chiefs of staff at which he alternately praised hospitals for their fine cooperation and devotion to duty, threatened to revoke their licenses for infraction of laws governing emergency care, and posed for newspaper pictures with hospital officials. The story was back on page one. The newspapers took little notice, however, when Ambulance Chief Joseph McCarthy of the Chicago Fire Department, whose service handles 10,000 emergency cases a year, said he had never heard of a single case in which emergency treatment was withheld because the patient couldn't pay.

At the Bundesen meeting, a hospital spokesman jumped to his feet to complain about the "unnecessary and unwarranted publicity" the Case had received. Hospital administrators and doctors applauded. A man with a nice ear for the high-sounding phrase, Dr.

Bundesen retorted that health department and hospital business should be conducted "in the cleansing light of public knowledge." He added that newspaper stories of the Case had alerted hospitals and would have the effect of improving emergency-room practice. Reporters applauded.

Nobody applauded when the coroner's jury at the Lingo inquest ruled the Woodlawn Hospital had been negligent in its treatment of the baby. At the inquest, Coroner McCarron had charged the hospital with two violations of city law—failure to notify police of the accident, and failure to have a licensed physician in attendance. Dr. Jaeger is not licensed. The coroner's physician said that in his opinion the baby died of burns. A doctor representing Woodlawn Hospital insisted the cause of death was unknown, in the absence of autopsy findings. A Cook County Hospital resident said *he* thought the baby died of pneumonia. The hospital's attorney accused Coroner McCarron of conducting a "kangaroo court." McCarron made a speech comforting the bereaved mother. The story including the hospital's reply to the charges of law violation was on page thirteen.

The government, the press and the hospital are indispensable institutions in a free society. *Pro bono publico.*

Text

LIKE hospital administrators, cab drivers, and sandpaper salesmen, doctors come in all sizes and types. Some of them are bright and some are dull, some are wise and some foolish, some good and some evil. Actually, like other human beings, doctors are complex mixtures of all these and a thousand other qualities—no two mixtures just alike, no one man the same thing today that he was yesterday or will be tomorrow, for each of us at any time is the product of his total experience, and experience never stops.

To a greater extent than do the members of most other groups, however, doctors share a common experience and hence a tendency, at least, to think and act alike under certain circumstances. This tendency is more often exaggerated than understood, but hospital administrators, nurses and others who work closely with doctors can nearly always identify what might be described as a typical "doctor response."

Unquestionably, the more thoroughly an administrator understands the nature of the "doctor response" the more effectively he can deal with the doctors on his staff, and the more effectively he can deal with the staff, the more successful he will be as an administrator. For the most part, administrators learn what they can about the doctor response by empirical or on-the-job observation, and, eventually, they may come to understand a great deal about doctors by this method.

Necessarily, however, this in-service training is slow and laborious, since it offers only brief, limited opportunities from day to day to observe the doctor at work—at only a few of his many tasks and in only one of his several characteristic environments. For administrators who want to learn more than these limited opportunities afford, and learn it faster, a new textbook is now available. The textbook is a novel* by a writer whose knowledge of medicine was profound and sympathetic. Morton Thompson, who died before this book was published, understood the frauds as well as the triumphs of medicine; as a wise parent loves a wayward child, he loved medicine without being blind to its faults.

Mr. Thompson's novel is the story of a boy with a passion to become a doctor. The boy grows up and goes to college, makes a marriage of convenience to finance his medical education, finishes medical school and internship with a brilliant record, and goes into general practice in a small town, where his professional colleagues include a capable, indefatigable practitioner with a peculiar horror of death and dying patients, an elderly doctor with high blood pressure, a pair of slick partners for whom medicine is strictly a means to an end and the end is money, and a brutal, callous, incompetent old-timer whose medical sins are the despair of the young doctor and the reader, if not the author.

In young Dr. Lucas Marsh and his associates in medical school, at the hospital and in practice, we see the essential elements of the common, shared experience that, eventually, makes doctors behave like doctors. The staggering tasks of memorization in first year medical school; the cadavers; the excitement of the first assignment to the wards; the examinations; the hero worship; the acceptance of rigid discipline, and, as the years pass and the ladder of caste is ascended, the emergence of the disciplinarian; the ritualistic practices of the operating room; the authority; the responsibility; the fears and idiosyncrasies of patients; the need to be omniscient—all these and many other experiences and feelings are the factors, and the "doctor response" is the ultimate product.

Dr. Marsh and the incompetent Dr. Snider are as unlike as human beings can be, and yet they are both doctors. When, in a dramatic episode near the end of the book, Dr. Marsh visits the chairman of his county medical society, proposing to bring charges of incompetence against Dr. Snider, the chairman is sympathetic but unyielding. *"It's not just Snider,"* he thinks as he listens to Dr. Marsh's complaint. *"It's a doctor. He's got his diploma. He's one of us. A part of you and a part of me. A part of all the men the society must protect."* And Dr. Marsh, listening with dismay to the chairman's refusal to consider his charges, thinks, *"The old, old priesthood, the priesthood that had never died. It was no myth. It was real. The parallel was exact. The priesthood did not try for murder. It tried for heresy. It protected its own. And Dr. Snider was a priest. And the ranks had closed."*

As a novel, "Not As a Stranger" is unconscionably long—more than 900 pages—and unstructured, with much detail that is unnecessary and some that is boring. It includes some affectations of style, such as periodic outbreaks of one-word paragraphs, that are distracting, if not annoying. But it is powerful stuff nevertheless. It has the power of authentic knowledge, the power of insight, and the power of art. It is a definitive study of the doctor in his native habitat. Hospital administrators and trustees will understand doctors better, and probably love them more, for having read it.

* Not As a Stranger, by Morton Thompson. New York: Charles Scribner's Sons, 1954.

Morals and motives — not manners or economics — are

The True Measure of Medical Ethics

MANY of us who paddle in the currents and eddies of the doctor-patient relationship and a few who merely sit on the ditch-bank in quiet astonishment have developed the vague notion that something must be wrong with the code of ethics our physicians presume to follow. This is not a new feeling, although it has been newly aggravated by the attempts of various small but vocal segments of the medical profession to establish that it is unethical for doctors publicly to protest unethical practices. (See *The Strange Case of Dr. Loyal Davis,* The MODERN HOSPITAL, June 1953.) This implication of "something wrong" is not, in this case, meant to refer to the wrongdoers. But the point here is that something is wrong with the ethics themselves.

The feeling of puzzlement which these ethics provoke, to cite one illustration, came two years ago to the religion editor of a Chicago newspaper. It occurred to her that it would be nice to have an Easter story from various persons on what their religion meant to them. The editor wanted statements from a lawyer, banker, merchant and doctor, among others. A general practitioner, interviewed on the phone, provided an excellent paragraph on how his religious faith helped him in caring for the sick. Perhaps momentarily overcome by contemplation of the beauty of Christian ethics, this doctor spoke from his heart, and what the editor saw there was pure. She showed the statement to the science editor, expecting him to be pleased with the eloquence of one of his doctors. "Oh, oh!" said the science editor, "You can get this doctor into trouble. Don't use his name without clearing it with the medical society. Better let me check it." The science man called the chairman of the medical society's public relations committee, who promptly disapproved publication of the G.P.'s name. Such publicity was unethical. Why? "Because," said the doctor, "it would give him an unfair economic advantage."

Lay resentment of such professional reactions is immediate, deep and long-lasting. The incident created a sense of outrage in the minds of the religion editor, the science editor and those to whom they related it. What nonsense! What pettiness! Everybody, it seems, but some medical society officials, understands that ethics are not intended to stifle and silence men of good will, much less protect the interests of those arbiters of humanitarianism, his jealous competitors. Ethics, the science and principles of moral duty, are not that small. Indeed, the 1949 edition of the American Medical Association's *Principles of Medical Ethics,* the moral guide of American medicine, says as much. "These principles of medical ethics," reads the conclusion, "have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community."

So we are well within the bounds of proper moral indignation in getting hopping mad when we see some doctors using their ethics to protect their own economic position or cut down

(*Continued on Page* 98)

I AM A DOCTOR AND THIS IS MY CODE:

1. I shall measure my success as a doctor of medicine by the service I give humanity and not the profit I take, placing the good of the patient above the good of myself and my family.
2. I shall do nothing to harm my patient's health or his life, but shall do my best to help all whom I attend.
3. I accept the responsibility for my patient's welfare so long as he obeys my orders and retains me as his physician; this responsibility requires that I guard the patient's trust and confidence and take no advantage of his helplessness.
4. The privilege of judgment and decision granted me requires that I defend my freedom to think, to speak and to act — and to respect the freedom of other physicians to do the same.
5. I shall not assume knowledge, experience or skill which I have not, but recognize my limitations and seek the consultation of those who may know more, for I am human and I am fallible.
6. I shall honor my teachers, freely share what I have learned, accept the friendly criticism of my colleagues and support the art and the science which give me the power to heal.
7. I shall seek the truth and the courage to uphold it, irrespective of insult or reprisal.
8. I shall oppose and protest those whose lack of moral or technical competence debases my profession and shall support those who elevate medical standards and guard public trust.

How Free Is "Free Choice"?

Insistence on free choice as a condition of a satisfactory doctor-patient relationship is a disservice to both, in this view

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THERE is almost no difference of opinion as to the best way of applying the principles of medical science, but there are strong differences of opinion—some of them disruptive and even explosive—on medical economics. Frequently, in fact, in this changing world of medical economics, we find the practitioner living in a constant state of alarm, fighting back resolutely but, in some instances, blindly, at straw men as well as real men. He seems ready to employ almost any defensive argument that may come to his troubled mind without regard to its applicability, its implications, or its effects. An insecure physician means an insecure patient and we must therefore search for a way to apply the principles of social security to him as well as his patients.

ARGUMENT IS UNWORTHY

Let us take, for example, the confidential relationship between physician and patient which everyone agrees should remain sacred. Is this relationship promoted at all times by the indiscriminate exercise of the right of selection upon which the practitioner insists as a condition to such intimacy? Can it not prevail where the right of selection is waived for any reason? The argument is too often befogged by a tendency to insist that this relationship is conditional on the right of selection. There is a further tendency to insist that the confidential relationship can only be established and maintained satisfactorily on the fee-for-service principle, yet this argument is unworthy of its author. It is not true that a patient cannot give his confidence to a physician unless he personally exercises the right of selection or is prepared to pay him a fee.

The confidential relationship between patient and physician should be blessed with universal application under all conditions of medical service. There can be no exception to such a rule. The fee-for-service principle and the right of selection must be thought out on their own merits. The right of selection on the part of a patient, who cannot possibly know on all occasions what is best for him medically, has definite limitations because misuse of such a right can defeat the desired objective. Insistence on this right as a corollary to the confidential patient-physician relationship is not only unrealistic, inequitable, bad ("smoke-screen") logic, and poor medical "public relations," it is a disservice to a profession which proudly wears its humanity on its sleeve. This confidential relationship should come into force promptly on the contact of both parties with each other, and remain firm, without regard to any other consideration than this vital therapeutic need. You cannot sell (a) the fee-for-service, (b) the right of selection, and (c) the confidential relationship in one package, so to speak, since they are not necessarily dependent on each other.

When all is said and done, the right of selection can only be granted at the present time to the patient who can afford a fee-for-service to cover the kind of care which he thinks he requires, and no one will maintain that this right is intelligently exercised on all occasions. Nor should privacy be purchasable. The right of selection must often be waived, as we know from the following circumstances:

The case of the prospective patient who is protected by the health department against illness through medical appointments which are beyond his direct control. He may or may not be in contact with these appointees, but his confidence in them, and his cooperation with them, precisely because they have been intelligently selected, is seldom in question. No fee-for-service is involved and the so-called confidential relationship makes minimal demands on either side.

NO "SELECTION" ON BATTLEFIELD

The case of the patient at the other extreme, who is taken sick suddenly and is given over into the confidential arms of a physician selected by others for him. In the military field of activity, the suspension of the right of selection stands out in bold relief and no one would consider such a successful arrangement a violation of the confidential relationship between patient and doctor. There is, literally, no time here to choose.

The case of the poor patient who cannot afford a fee-for-service, who is medically indigent, and has a physician assigned to him by those in authority who are legally and morally bound to obtain the best available for him, in the ward, outpatient department of a

hospital, or elsewhere—an arrangement which, by the way, seems to be conducive to the highest scientific good. The impersonal relationship which too often prevails under these circumstances is thought to be of lesser consequence to the patient than the lavish work-up (without cost to him) which he more often receives. If an impersonal relationship exists on this or any other occasion, the responsibility rests with the attending physician. Where this responsibility is denied, the patient has, in effect, lost this vital adjuvant to his cure because of his poverty. It would be well to consider the relative merits of "ward" and "private" care in a hospital from this angle.

PATIENT'S RIGHTS WAIVED

The case of the patient who requires the services of a specialist and exercises his right of selection through his physician—a highly intelligent method, by the way. As the number of physicians multiplies in accordance with the requirements of his illness, the patient's continued right of selection must be waived and transferred to more knowing minds for his own protection. There are indeed times, however infrequent, when additional physicians must be brought in to correct a mistake in selection at the outset. In any event, the confidential relationship remains unmolested.

But there is more to this subject than the circumstances under which the suspension of the right takes place. For example:

The right to select any physician, at will, involves the right to select no physician at all if the sick man (sick mentally or physically) is so minded. Since illness involves more people than the patient himself, we must constantly strive for a plan of medical care which can be adjusted to his exact requirements. To give him an inalienable right of selection regardless of the consequences may be the worst thing for him.

It must also be remembered that this right of selection is sometimes exercised too late in the course of illness. Whatever the reasons, the fact remains.

The right to select any physician also involves the right to be selective about specific medical or surgical treatment which that physician might prescribe. Very few people are correctly intuitive about such things. In actual practice this is also proved when (a) the patient discharges himself prematurely from the hospital against the advice of the medical staff, (b) when he "cheats" with his medication and his diets, and (c) when he changes physicians in mid-illness, leaving the original physician of his choice in the darkness as to the outcome of the case. The right to select thus involves the right of a sick man to change his mind or to repudiate medical competence inconsiderately. Does the patient always know what is best for him and, if he does not, can we elaborate a better way of advising him than that which prevails when he takes a stab in the dark or responds to the advice of ill-informed friends?

We know that a physician cannot be judged by his absolute mortality rate, nor is his comparative record for successful cures an infallible guide in all cases. The best doctors do not shy away from medical or surgical risks. Yet we find otherwise intelligent people still impressed with such considerations.

What are the legitimate means of attracting and holding patients?

THE RIGHT TO WRONG CHOICE

The right to select any physician involves the right to select a cultist or even a quack. It also involves the right to lean heavily on the corner druggist at the wrong time. It encourages the presence of the bone-setter as well as the religious "scientist." Can we depend upon the unaided sick to decide the value of these eccentric activities in relation to the values within the medical profession?

Having legislated a licensing act for physicians, and having latterly established superqualification in the form of certification, we have accepted the principle that the right of selection must be modified at times. We have invaded this right of the individual patient by qualifying and certifying the panel of physicians from which he must make a choice. How much farther may we go with this kind of help and is any of the confidential relationship between doctor and patient lost in the end-result?

The most intelligent group of patients, from this point of view, are the physicians themselves during personal illness. The layman is more heavily dependent on good luck or coincidence. He might hit the bull's eye, so to speak, but his aim is too uncertain to be reliable. He needs help in selection. A physician is, or should be, a dependable judge of the right man for the right patient at the right time. However, we shall not know the ideal way to select a physician until we are able to establish a balance between emotion and logic in each case and the sooner this is done the happier will be the results.

Any one of us can recall instances in which one of the postmortem findings was the exercise of poor judgment in medical or surgical selection. Nor can any of us ever know the extent to which poor judgment of this kind may be responsible for the establishment of prolonged illness. Men of great prominence, as well as others, have gone to their graves who could have been spared to us for more years if a more correct selection had been made at the right time. Selection, in other words, presents hazards and must therefore be carefully guided. Simply to insist on the right without suggesting criteria for selection is not enough!

In spiritual matters we find that the right of selection is very strictly limited. Though a parishioner may from time to time decline to say his prayers because he dislikes the clergyman, the method of selection appears to work to the benefit of the vast majority. The same can be said for the method of selecting teachers for our public school system. It may have its faults, but the denial of the right of indiscriminate selection is not one of them. The comparison, while not wholly parallel, is suggestive.

IT IS ONE-WAY PRIVILEGE

The right of selection is, in effect, a one-way privilege. The patient may select his physician if the circumstances are favorable to the exercise of his right but, as matters now stand, can the physician be equally selective of his patient and, if not, what becomes of the emotional tie between the two which is so vital to therapeutic success? The practitioner or specialist can raise his fee in an effort to exclude undesired patients, but this economic weapon of self-defense is abhorrent to a sensitive medical man. He can also employ other methods such as "lack of time," or frankness in stating the reason, but this too is exceptional under the temptations and distractions of the fee-for-service principle. Where patient and physician are properly adjusted to each other the confidential relationship is enhanced.

What does it profit a sick man when he wants a certain physician's services and cannot afford his fees? Assuming

that he may be mistaken in his judgment of price and value, are we not obligated to find a safer and more productive formula for him that will enable him to obtain, by a modified form of selection, what he needs medically when he needs it, without jeopardizing the confidential relationship with his physician?

The right of selection encourages insidious advertising and puts a premium on glibness and salesmanship. The most popular practitioner—the physician with the highest income—is not by this fact the most scientific. Yet popularity of this kind snowballs with time, on the assumption by some people that so many patients cannot be wrong. Under the strictly applied principle of the right of selection, such a physician is favored before his more competent colleague who may be the better diagnostician and therapist in specific instances. A competitive element is here introduced which is unwholesome and misleading. Every person should enjoy the privilege of choosing his own doctor and this should not be denied to him. How can we help him to make wise decisions? It is to this aspect of the matter that the practitioner should direct his attention.

PARTIAL SOLUTION IS POSSIBLE

So long as human judgments remain fallible we may have to forego perfection as we strive to approximate it at all times. But an admission of fallibility should not freeze us into a false position where inability to solve a problem completely prevents us from solving it partly. We shall make fatal mistakes at times, but we shall make fewer of them with a better understanding of the relation of service to need, and the better the understanding the more sincere and the stronger should be the confidential tie which binds physician and patient.

The point of all this is that the practitioner, in an attempt to safeguard the confidential relationship with his patient at all costs, worried that all he has lived for might be taken from him, has magnified out of all proportion this right of selection—a right which ought to be intelligently analyzed and synthesized and put to work constructively for the benefit of both physician and patient. The practitioner too often exposes himself to criticism when he leans on the unrestricted right of selection to secure his economic position. This problem belongs in the educational field and should be solved at an early date before the practitioner loses all in his efforts to retain all. In no other way can we avoid the extremes of nationalization which would be a demoralizing alternative.

A doctor believes

Healing Must Include the Spirit

WE HAVE all heard the old saying that doctors are notoriously poor businessmen. What does this imply? My evaluation of it is that doctors were so concerned about the patient that they gave no thought to whether or not the patient could pay for the services rendered. They were completely engrossed in their profession, caring for the sick. That was the state of most doctors some years ago. Then we entered an era of professional budget plans and medical economics and we have, in later years, heard so much about making money that some of us care for our patients according to what it will do for us financially rather than as a professional duty and a moral obligation.

What is there in it for me? Are we becoming materialistic and selfish? Have we become cynical? Do we not feel we are here to help society? Young people dream dreams and have ideals. Are we so callous and cynical that we can no longer cling to these ideals? When you were a small boy and looked forward to the day you would be a doctor, weren't you moved by the ideal of helping others simply because they needed help? Wasn't the bright vision of aiding suffering humanity enough to spur your ambition to be a doctor? Was that really just "kid stuff" or was it something real and good and fine? Must it necessarily be lost when we reach our goal, when we realize those boyhood dreams? Can we retain some of that grand idealism that lighted our dreams as youngsters? I hope we can.

It would do us all good to meditate on the nobler aspects of our profession. It is extremely gratifying to see that during this materialistic, dollar-hungry age, there are many doctors dedicating a great deal of their time to work for the handicapped—a work which we all know is more of a financial burden than a reward. There is immense satisfaction in rehabilitating these recluses and handicapped people and making them more fully equipped to carry their share of life's load instead of being dependent on the rest of society.

Some of these afflicted people have tremendous courage, and this courage is an inspiration to the doctor. But many of them need our help; they are weak in body and mind and faith in life. We have to possess a deep spiritual feeling if we are to be able to give it to them. It is not sufficient to say, "Keep your chin up!" We must give them something solid. Even if we are not religious ourselves, we doctors would do well to try to feel this and pass it on to these patients, because they need it.

What do they have to live for? Why keep their chins up? This isn't easy to answer, and we first must be able to understand suffering. The doctor's business is healing, and there are frequent occasions when we cannot heal physically and must think of the other kind of healing—of the spirit.

We doctors are ambassadors of God. The strongest sermon we can preach is the example we set.—*Condensed from a talk by* DR. AELRED FONDER *of Winnetka, Ill., February* 1954.

Design Trends

THE ERA OF AMBULANT PATIENTS

FOR YEARS, hospital theorists have been concerned about the integration of inpatient and outpatient services, but hospital planners and builders, responsive to existing practice, have usually given outpatient facilities the basement or back-door treatment. Now, suddenly, the Era of Ambulant Patients is upon us, with the Commission on Financing Hospital Care urging outpatient expansion as a principal route to fiscal salvation, with President Eisenhower recommending federal aid for construction of diagnostic centers and rehabilitation units, and with authorities on all sides emphasizing the needs of long-term patients. As the Era of Ambulant Patients dawns, The MODERN HOSPITAL reports how some of these new problems are being met. Further reports will appear in subsequent issues of this magazine.

Exterior of the clinic building, Kaiser Foundation Hospital, Walnut Creek, Calif.

THE AMBULANT PATIENT COMES OF AGE

The doctor's office comes to the hospital

The hospital becomes a community health center

The outpatient department is humanized

Outpatient facilities and ancillary services on one floor

A hospital core—no hospital beds

ROSLYN LINDHEIM
Architect, Berkeley, Calif.

THE hospital bed is but one element in health facility planning today. Modern medicine has the know-how to control diseases before they become chronic, before a patient requires a hospital bed, while he is still ambulant and at his job. The specialization of doctors, the need for the resources of diagnostic and therapeutic equipment, the laboratory and x-ray as necessary supplements to the doctor's handbag, are the foundations on which most of the recent developments in medical care rest.

In the past most of the architect's attention was concerned with housing bed patients. The focal point of hospital planning has been hospital beds—how many for what price. The ancillary services of the hospital served bed patients primarily. Some hospitals as quasi-social institutions established outpatient departments. The size of the O.P.D. was the product of the finances of the hospital rather than the needs of the community. Even in the cases where the outpatient department was brought out of the basement and bright colors and casual chairs supplanted the rows of hard wooden benches, the concept "outpatient" was synonymous with "poor patient."

An important architectural problem was waiting space, because a uniform characteristic of O.P.D.'s was waiting. The outpatient seeking advice was thus thrice penalized, (1) for being poor, (2) for being sick, and (3) for waiting and thereby losing time he or she could ill afford from work or household and child care responsibilities. It is little wonder that people stayed away unless their symptoms became so severe they could no longer ignore them.

The experiences of H.I.P. in New York, a prepayment health insurance plan, indicate that 77.7 per cent of the medical care rendered is in office or clinic. The architect is faced with a new challenge, the housing problem of the ambulant patient. The ambulant patient of today has very complex needs. He requires specialists as well as general medical care; he needs the services of laboratory and x-ray. He is becoming educated to the fact that a "stitch in time saves nine" and no longer wants to wait for serious illness to strike before he avails himself of medical treatment.

The "coming of age of the ambulant patient" has required changes in architectural forms, the development of new building types. Some of these changes have been the result of gradual evolution, others have been planned in response to the new requirements. The ambulant patient, unfortunately, has not displaced the bed patient. It will be a long time before the gap that exists between actual and required beds is filled. But the impact of the ambulant patient on existing facilities and the requirements for new housing deserve the attention of both architectural and medical professions. A birds-eye view of some of the recent architectural developments might help focus attention on trends, solutions and requirements, so that future physical plants will best implement future medical programs.

The Doctor's Office Comes to the Hospital
The Hospital Opens Ancillary Services for Private Patients

The grouping of small doctors' office buildings near existing hospitals is a clearly discernible trend. Not only is time saved for the doctor by being close to his bed patients, but proximity to the hospital enables him easily to refer his ambulant patients to the hospital for x-ray, laboratory and other diagnostic and therapeutic work. A multitude of these small doctors' office buildings are to be seen on the West Coast, and an ever-increasing number is being built in the South and Midwest. These doctors' office buildings, interestingly enough referred to as "clinics" by many lay persons, are a group of private offices. Sometimes a reception room is shared by two or more doctors. Good

business sense operates like "natural selection" and, as in a shopping center, a variety of medical specialists is often to be found under one roof. The utilization of the ancillary services of the hospital by the referral of private ambulant patients has taxed these services to the point that many hospitals are having to think in terms of expanding these facilities. The emergency room of the hospital has also been utilized by private doctors. In case of any off-hour, even minor, injury a doctor will say "meet me in the emergency room" and there he is sure of the availability of any ancillary service he might need. The increased use of these facilities has proved a source of income to the hospital, and in many cases has meant better medical care for both inpatient and outpatient as well. With the expanded use of facilities, a full-time radiologist and pathologist can be employed in many cases where heretofore these services had been staffed by part-time men.

Conversations with private physicians have indicated to me that still greater use would be made of the ancillary services by ambulant patients if some form of insurance would cover this service. Under present-day coverage a doctor will often hospitalize a patient who needs extensive and costly x-ray and laboratory service because a portion of the cost will be covered by insurance if he occupies a hospital bed, although the same diagnostic procedures could be adequately performed while the patient is still ambulant. A striking example of the concentration of doctors' offices around the hospital can be seen by driving to "Pill Hill" at Oakland, Calif., where a multitude of small office buildings have grown up like mushrooms surrounding the three hospitals on the summit.

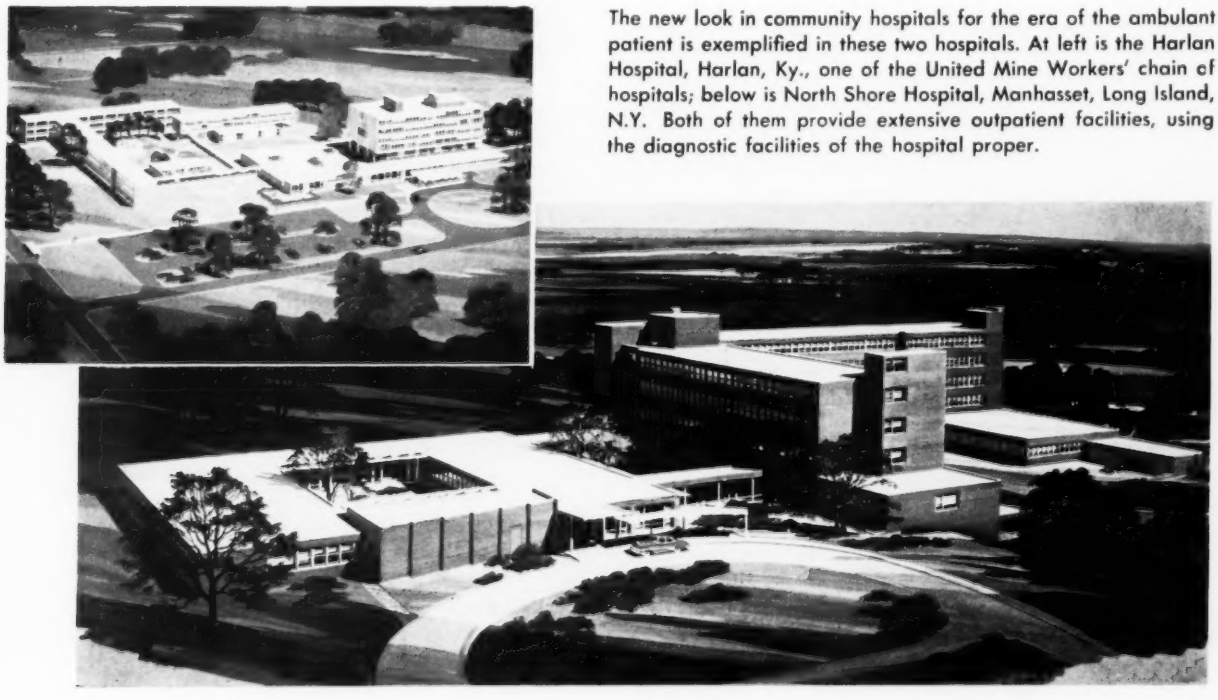
A more conscious expression of the doctor's office coming to the hospital can be found at the Bristol Memorial Hospital, Bristol, Tenn. In this case it was the architect, A. L. Aydelott, who took the lead. Despite the objections of the doctors that it would be disadvantageous for them to move a mile and a half from downtown, the doctors' wing of the hospital went up. All of Bristol's 26 physicians have since moved in, and the combination of physicians' office and hospital was so well liked that it has already attracted five outstanding young specialists. Each doctor has two examination and treatment rooms, a consultation room, waiting and reception area, and a private toilet. The physicians' building is joined to the nursing wing by the facilities both use. Because the ancillary services get continuous use the 120 bed hospital can employ a full-time radiologist and pathologist.[1]

The Hospital Becomes a Diagnostic Center—A Specialist Center—A Community Health Center—Serving Country Doctors in a Rural Area

Hunterdon Medical Center located in Flemington, N.J., has 106 beds but it also has a unique program of preventive medicine, a staff of eight full-time, salaried specialists, complete radiologic facilities and a clinical laboratory headed by a pathologist. The hospital contains examination and treatment rooms as well as offices for the specialist staff. The local G.P.'s who are on the hospital staff bring their ambulatory patients as well as their bed patients to the hospital for diagnostic procedures and consultations. The people in the area have the G.P.'s as their personal physicians and the whole specialist staff of the hospital as their "group practice" consultants. The members of the staff are also faculty members of New York University Medical School, which has an exchange teaching program for a number of community hospitals not far from New York City.

At night 8000 Flemington residents are getting half-hour

[1]For detailed plans and description of this hospital see The MODERN HOSPITAL, July 1951.



The new look in community hospitals for the era of the ambulant patient is exemplified in these two hospitals. At left is the Harlan Hospital, Harlan, Ky., one of the United Mine Workers' chain of hospitals; below is North Shore Hospital, Manhasset, Long Island, N.Y. Both of them provide extensive outpatient facilities, using the diagnostic facilities of the hospital proper.

multiphasic tests. Others are getting complete workups paid for by a Commonwealth Fund grant. I visited this institution shortly after it opened, when the ambulant patient had not quite yet come of age. The latest report is that "four months after the opening there is already a problem of short space. Facilities are getting more use from ambulant than from bed patients."[2] This is an interesting test tube case, not only of ways and means of integrating public health, preventive medicine, diagnosis and treatment in a rural community hospital but also of utilization of facilities for ambulant patients. Here some of the barriers between preventive and curative medicine were let down and the response provides some indication of the scope of service and consequently the extent of plant required by ambulant patients.

The Outpatient Department Becomes Humanized

The outpatient department of the Kaiser Hospital at Walnut Creek, Calif.,[3] is an example where outpatient really means "out" patient as distinguished from inpatient rather than outpatient as synonymous with poor patient. The housing of the ambulatory patient in a separate facility does much to create a scale of operation which produces a much more intimate feeling. Note how each doctor has a consultation room as well as examination and treatment rooms, as compared to the curtained cubicle arrangement in the standard outpatient department. The housing of the pediatric outpatient department in separate facilities further reduces both noise and size. This building is an interesting example of a method of treating ambulatory patients as a special function but still using the ancillary services of the hospital. The planting, the location, the scale, all contribute to making this an extremely pleasant place to visit. The same relationship of inpatient and outpatient facilities and diagnostic services may be seen in the Kaiser Medical Center at San Francisco, where, however, inpatient and outpatient departments are under the same roof, instead of in separate buildings, as at Walnut Creek. See plans on page 59.

The North Shore Hospital[4] at Manhasset, L.I., is another example where attempts were made to humanize the ambulatory facilities. Here the community services, consisting of auditorium, the outpatient department, doctors' offices, a demonstration room and various offices, such as for the local Red Cross, women's auxiliary, visiting nurses and health officers, are arranged around a planted patio and linked to the ancillary services by glass passageways.

The Hospital Integrates Outpatient Facilities and Ancillary Services on One Floor

The recognition that ambulatory patients are going to use the ancillary services of the hospital even more than the inpatients and, consequently, that close proximity between ancillary services, particularly laboratory and x-ray, and ambulatory patients is essential to minimize cross circulation, has produced a new development in hospital planning in which the entire first floor of the hospital is devoted to these two functions. All of the plans of the United Mine Workers' hospitals now under construction have the outpatients and the ancillary services on the first floor with the bed patients above and plans for bed expansion vertically. Particularly in Harlan Hospital[5] the placing of laboratory, physical medicine and radiology departments permits easy access for ambulatory patients. Also worthy of note in this hospital chain is the proportion of space devoted to the combination of outpatient and ancillary services with respect to bed patients.

A Hospital Core—No Hospital Beds

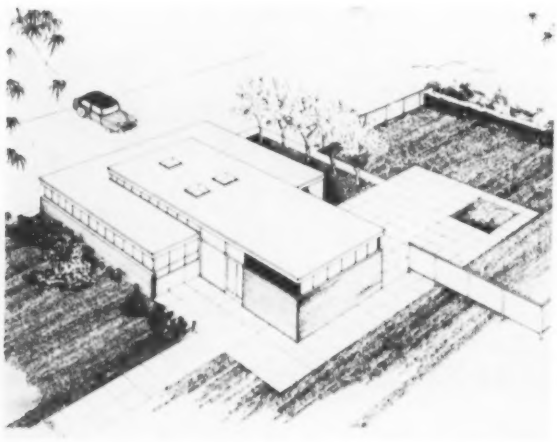
A new building type has developed which contains more ancillary services than many 100 bed hospitals yet it is only for ambulatory patients. It has doctors' offices yet it is more than a professional building. This building type, the group practice medical center, has importance because it is a conscious attempt to provide under one roof all the facilities required for the prevention, diagnosis and treatment of ambulant patients. This building houses the examination, treatment and consultation space of a variety of medical specialists; the number and type varies with the scope of medical service and the needs of the community. In this form of medical practice consultation among the various medical specialists is encouraged and not hampered by fear of losing one's patient to another doctor; the method of payment to doctors is based on some prearranged agreement independent of the fee charged to individual patients.

Most of the group practice medical plans now refer patients who need hospitalization to existing hospitals not connected with this ambulatory facility.

There is a tremendous variation throughout the country in type, size and composition of group practice units, which is reflected in their buildings. Many groups are housed in makeshift quarters. The larger groups contain facilities for x-ray and laboratory, physical therapy, minor surgery, superficial and, in some groups, deep therapy. Joint use is made of office facilities, records and auxiliary personnel. The ambulatory patient who patronizes the group practice

[2]For detailed plans and discussion see: Harper's Magazine, June 1952; Medical Economics, March 1953; Architectural Forum, January 1952, and December 1953.

[3]See page 71 of this issue for detailed plans.



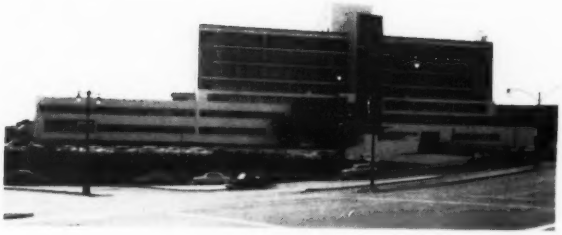
The Carter County Health Center, Carter County, Tennessee, designed by Alfred L. Aydelott, Memphis, Tenn., illustrates a modern design for a health center facility.

[4]Hospital of the Month, The MODERN HOSPITAL, December 1951.

[5]For detailed plans and discussion see The MODERN HOSPITAL, November 1953.

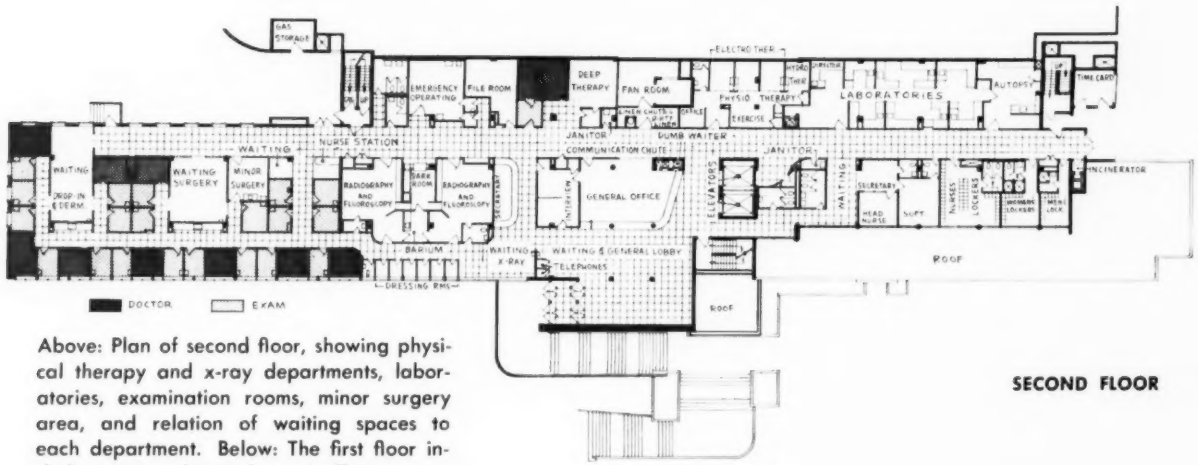
THE KAISER MEDICAL CENTER, SAN FRANCISCO

Left: The Kaiser Medical Center, now under construction in San Francisco, was designed by Wolff and Phillips, architects, Portland, Ore. Inpatient and outpatient departments are under one roof.



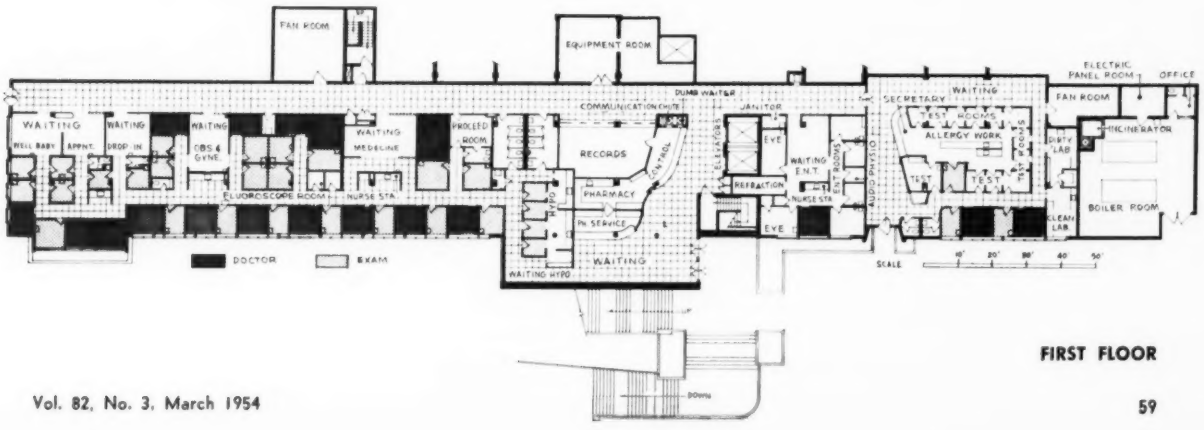
Above: Plan of the third floor which houses the labor and delivery rooms, nursery and maternity unit. Private nurseries adjoining mothers' rooms are shown by dotted areas.

THIRD FLOOR



Above: Plan of second floor, showing physical therapy and x-ray departments, laboratories, examination rooms, minor surgery area, and relation of waiting spaces to each department. Below: The first floor includes various clinics, doctors' offices, examining rooms, record room and pharmacy.

SECOND FLOOR



FIRST FLOOR

medical center is not a charity patient. He is either a paying patient or a prepaid patient. He is not an outpatient in the old sense of the word. He wants all the amenities of private practice plus the convenience and medical service offered by the availability of both specialist and equipment in one spot.

The group practice of medicine presents new architectural problems without precedent in any outpatient department of a hospital or the private doctors' office building. There have been numerous solutions to the type of examination and treatment rooms. Some groups have combined examination, treatment and consultation. Others provide one consultation room to two examination rooms. Still others have the flexibility of arrangement so that a doctor has two or more examination and treatment rooms at his disposal. The solution to the question of waiting space is also solved in numerous fashions, but in every case attempts have been made to do away with the "clinic" atmosphere, to ensure privacy for the patient.

A good deal of medical consultation takes place in the corridor and one of the architectural problems of this type of building is so to place the facilities that those doctors who most often need to confer can do so with minimum loss of time and motion. The focal point of this building is the ancillary services. The correct location of the different specialties to these services is a means whereby traffic is cut down and consultation brought up. The Labor-Management Clinic in Philadelphia is an example in which considerable thought was given to functional relationships and pleasant atmosphere.[6] An interesting example of a centralizing waiting area which at the same time creates a small, intimate feeling can be seen in the Beverly Hills Clinic, Los Angeles. The different forms of organization of these groups, particularly those with prepayment plans where certain medical specialists only operate on a part-time basis requires exploration into the architectural solutions of creating multipurpose examination and treatment rooms so that dual use of facilities can be made.

The question of group practice of medicine as a form of medical organization for the treatment of ambulatory patients gives rise to certain questions which in turn have their architectural repercussions. How big should a group be? At what point are the advantages of group practice, of informal consultation, of intimacy between patient and doctor, lost by becoming too big? Also how big must a group be to warrarnt the expensive equipment so necessary for ambulant care, so as not to waste these expensive facilities? Some groups have already established what might be called a regional approach to ambulant facilities whereby a central diagnostic unit houses all the ancillary equipment and full-time specialist staff, while smaller clinic "outposts" take care of the minor illnesses which do not require the same complete service. The smaller units refer patients to the central facility when needed. The Ross Loos group in Los Angeles, for example, has one central diagnostic unit and 13 smaller medical outposts.

The Future of Health Facility Planning

Many conclusions may and must be drawn from these trends. One fact stands out. Ancillary services are no longer ancillary. They have become the center of gravity of modern medicine, necessary for the ambulant patient as well as the bed patient. It is the ambulant patient who is increasingly using these facilities.

What is going to happen as the hospital opens its doors to an extended program of preventive, diagnostic and curative medicine for the ambulant patient? What is this going to mean in terms of space and equipment, in terms of staff and operating personnel, in terms of laboratory and x-ray? Obviously the O.P.D. designed for emergency cases and charity patients, for temporary medical treatment of a specific ailment, cannot under its present conception and present facilities care for this increased load. In order for the outpatient department adequately to care for ambulant as well as bed patients it must be operated on a par with hospital inpatient service. This will require changes, both economic and administrative, as well as extended physical plant.

By how much do the ancillary services have to be increased in order adequately to care for both inpatients and outpatients? We know a hospital of a specified size has certain requirements and these requirements are recognized as contributing factors to the cost of each bed. We even have a ratio as to number of beds required per thousand of population. Early ambulation, home care and how we meet the needs of the ambulant patient will change this statistic. It is not a static figure. But with regard to the needs of the ambulatory patient we are just beginning to develop a body of information from the experiences of some of the prepayment plans as to what the utilization of ancillary services may be when a complete program of preventive, diagnostic and curative medicine is practiced. These figures tell only part of the story, because they are based on special segments of the population, and there will be variation as to requirements depending on location, education, previous medical care, and character of population. In the past our thinking has been directed toward facilities to house the sick. Now our problem is not only places to cure the sick but medical facilities to keep people well.

In what manner will these ancillary services expand and how will this affect the hospital form? The Sodersjukhuset Hospital in Sweden duplicated two separate x-ray departments under one roof, adjacent but each a self-contained unit. Is the concentration in one spot of all diagnostic and therapeutic facilities the best or the most economical method of serving the ambulant patient? Are the needs of the ambulant patient and the bed patient sufficiently the same to warrant housing under one roof or even on the same site? Should we bring the ambulant patient to the hospital or should we apply the department store principle of establishing ambulatory "hospital branches" in the centers where people live? What effect will the extension of prepayment plans, the group practice of medicine, the regionalization of health facilities have on the function and form of our buildings?

Today the housing facilities for the ambulant patient are in the formative stage. The examples discussed are examples of trends rather than final conclusions. Obviously there will be no pat answers. Solutions will vary depending on specific local needs. The architectural design of health facilities cannot be divorced from the practice of medicine at a given time. The development of plant is in fact shaped by medical progress. Some of the underlying principles of organization, scope of service, method of treatment for the ambulant patient must first be formulated in order for the architect to translate them into spatial relationships. The clarity of underlying principle is the foundation upon which architectural solutions rest.

[6]For detailed plans see Hospitals, January 1950.

Left: Entrance to the Kaiser Foundation Hospital at Walnut Creek, Calif. Above: Roof eaves overhang the exterior walls, forming an outside visitors' corridor or covered lanai porch which protects the visitor from the rain in winter and the patient from the sun glare in summer. Visitors enter patients' rooms through ceiling-high glass doors.

At Walnut Creek Hospital

Efficiency Centers on the Corridor

THE MODERN HOSPITAL OF THE MONTH

CLARENCE MAYHEW
Architect, San Francisco

SIDNEY R. GARFIELD, M.D.
Medical Director, Kaiser Foundation, Oakland, Calif.

THERE is a story behind the floor plan of every well designed hospital. As every medical director and hospital consultant knows, hospital plans don't just happen, they evolve from an attempt to solve the many planning problems that are part of a hospital operation. The floor plan elements which Dr. Sidney R. Garfield, medical director for the Kaiser Foundation, worked out for the Walnut Creek Hospital, Walnut Creek, Calif., are no exception.

The original unit of the hospital was designed for 74 beds consisting of eight pediatrics, 16 maternity, and 50 general nursing. However, in view of the enthusiastic public reception of the hospital and to anticipate the needs of the physicians of the community, the trustees of the Kaiser Foundation decided to start immediate construction of a 20 bed addition which is scheduled to be ready for patients by the time this article is published.

As an architect who had had no previous experience in hospital work, I was particularly interested in the fundamental reasoning behind the many plan innovations which Dr. Gar-

field has used in designing his recent hospitals.

The idea of a "Nursing and Utility Corridor" is the basic plan pattern around which the entire hospital is designed. This new concept resulted from a never ending search for ways to improve patient care by increasing the efficiency of the nurse. Over the years many time-saving devices, such as intercommunicating systems, pneumatic tube systems, bedpan washers and sterilizers, and so on, have been incorporated in the hospital plan to help the nurse do her work. However helpful these mechanical aids might be, Dr. Garfield felt that the real problem or obstacle to efficient nursing was not being overcome.

What is the problem? Simply stated the problem is how to cut down the wasted nursing time that the nurse spends in walking between the nurses' stations and utility room and the patient's room, and increase the productive time that the nurse spends in patient care. In other words, the patient's charts, medicines, treatment materials, equipment and utilities which the nurse uses in her work are too far removed from the patient. The solution was to locate the patient's charts, medicines, treatment materials, equipment and utilities along the central corridor walls and directly behind the patient's room and route public traffic through outside corridors. The central corridor becomes work space, and the nurses' station, utility equipment, drugs, x-rays, treatment materials, instruments, linens, charts and so on for each patient can be kept in this work space just behind the patient's room.

The benefits are many. This new plan saves six out of every seven steps a nurse takes in a conventionally designed hospital. The nurse and other personnel are close to the patient, which facilitates answering calls, and obtaining medications and permits closer observation. The physician before entering the patient's room has the entire record in front of him: the chart, temperature, pulse, medications, treatment, diet, x-ray film and laboratory reports. He knows at a glance what the patient is receiving, what should be stopped or changed, thus eliminating wasted time and medicines. The nurse has the same information available to simplify the distribution of drugs, treatment and diets.

In the Walnut Creek Hospital, the roof eaves overhang the exterior walls 8 feet 6 inches, forming an outside visitors' corridor or covered lanai porch which protects the visitor from the rain in the winter and the patient from the sun glare in the summer. The visitor enters the patient's room through ceiling-high, glass sliding aluminum doors which comprise the exterior wall of each patient's room. These doors may be opened to any degree to admit the soft California breezes, or the patients can be rolled onto the lanai terraces which run on both sides of each of the three wings of rooms.

The plan of the nursing and utility corridor breaks down into nursing units of eight beds served by one nurse. At Walnut Creek all of the nursing rooms are private, with only the maternity rooms being double.

(*Continued on Page 67*)

Reception and Control Center

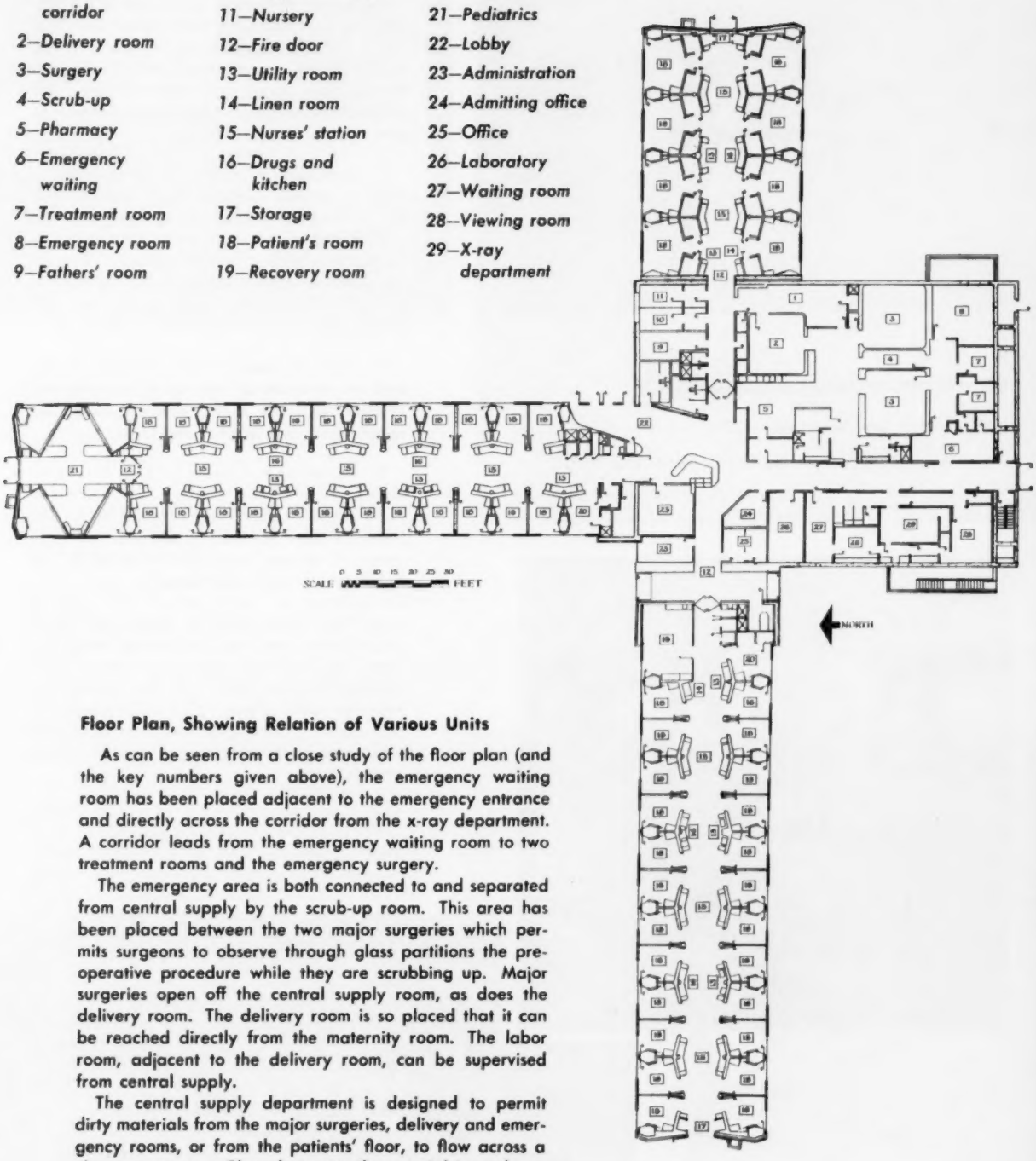
Central control is maintained by a supervisor at the control desk in the central entrance lobby. The control desk is so located that the supervisor has clear vision down each of the three nursing and utility corridors and the emergency corridor.

Also in attendance at the control desk are a receptionist who directs visitors down the outside corridors and answers requests for information, and the telephone operator, who handles calls and pages doctors over the intercommunication system.

Materials from the hospital's central pharmacy, laboratory, x-ray, central supply or business office are requested and delivered by a 4 inch diameter pneumatic tube system.

KEY TO FLOOR PLAN

1—Obstetric corridor
2—Delivery room
3—Surgery
4—Scrub-up
5—Pharmacy
6—Emergency waiting
7—Treatment room
8—Emergency room
9—Fathers' room
10—Suspect nursery
11—Nursery
12—Fire door
13—Utility room
14—Linen room
15—Nurses' station
16—Drugs and kitchen
17—Storage
18—Patient's room
19—Recovery room
20—Isolation
21—Pediatrics
22—Lobby
23—Administration
24—Admitting office
25—Office
26—Laboratory
27—Waiting room
28—Viewing room
29—X-ray department

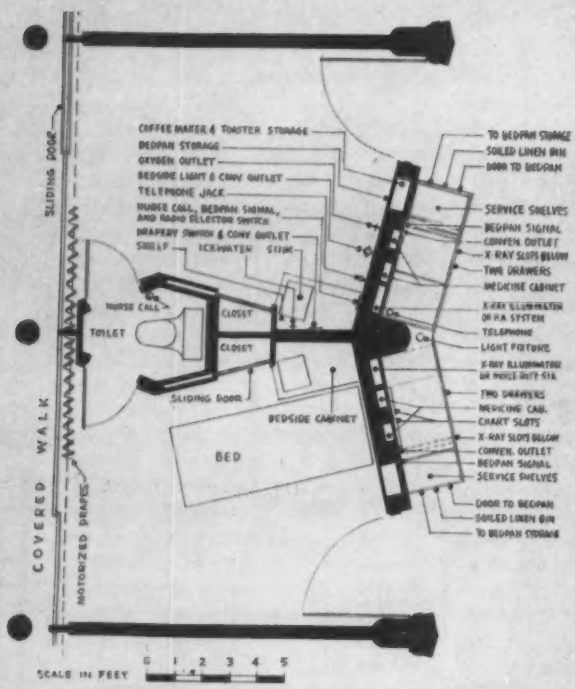


Floor Plan, Showing Relation of Various Units

As can be seen from a close study of the floor plan (and the key numbers given above), the emergency waiting room has been placed adjacent to the emergency entrance and directly across the corridor from the x-ray department. A corridor leads from the emergency waiting room to two treatment rooms and the emergency surgery.

The emergency area is both connected to and separated from central supply by the scrub-up room. This area has been placed between the two major surgeries which permits surgeons to observe through glass partitions the preoperative procedure while they are scrubbing up. Major surgeries open off the central supply room, as does the delivery room. The delivery room is so placed that it can be reached directly from the maternity room. The labor room, adjacent to the delivery room, can be supervised from central supply.

The central supply department is designed to permit dirty materials from the major surgeries, delivery and emergency rooms, or from the patients' floor, to flow across a clean-up counter. Clean but unsterile material is made up into packs on a loading table, loaded into wire mesh containers, and rolled to the sterilizers. Sterile material is stored in glazed cabinets ready for use when needed. A supply of the medicines and medications that are used oftenest is stored on shelves adjacent to the corridor service window.



TYPICAL BEDROOM IN GENERAL NURSING WING

Design and Equipment of Nurses' Stations

The nurses' stations on either side of the corridor have similar equipment except that Station A (below) has two x-ray viewers, whereas Station B (left) has an intercommunicating system speaker, nurses' call system buzzer, and pneumatic tube station. Equipment common to both is as follows:

1. Each end of lower counter adjacent to door of patient's room: (a) Horizontally hinged door to bedpan compartment so that nurse can remove bedpan without entering the room. A similar door opens into the patient's room so that sterilized pan is accessible to the patient. (b) Horizontally hinged door to dirty linen bin for storage of dirty linen until it is picked up.

2. Front of lower counter: (a) Two vertical slots on each side of leg space for x-ray envelopes. (b) Four sliding drawers above leg space for clerical supplies and forms.

3. Top of lower counter: (a) Four slots to receive patient's chart holders. (b) Charge-a-plate press for imprinting patient's name and charge number to medicine and laboratory orders. (c) Double swivel arm desk lights. (d) Telephone to main switchboard.

4. Wall above the lower counter: (a) adjustable shelves for linen, food and medication trays. (b) Four flush, open-faced cabinets with medication charts below. (c) Two double convenience outlet plugs. (d) Double jewel bedpan signal control light, turned on by patient when used bedpan has been placed in bedpan compartment.

Design and Equipment of Drug and Kitchen Units

Equipment included in the drug and kitchen units (above left) is as follows:

1. Each end of lower counter adjacent to patient's room: (a) Horizontally hinged door to bedpan compartment. (b) Horizontally hinged door to dirty linen bin.

2. Front of lower counter: (a) Bank of drawers. (b) Double locker. (c) Controls for electric hot plate. (d) Waste can. (e) Single locker. (f) Four cubic foot electric refrigerator.

3. Top of lower counter: (a) Built-in enameled iron sink. (b) Hot and cold water faucet. (c) Ice water glass filler. (d) Double electric hot plate. (e) Built-in enameled iron sink. (f) Hot and cold water faucet.

4. Wall above the lower counter: (a) Adjustable shelves for linen, food and medication trays. (b) Double convenience outlet. (c) Wall locker. (d) Circular structural column. (e) Wall locker. (f) Combination double jewel bedpan signal and double convenience outlet.

Design and Equipment of Utility Units

Equipment included in the utility units (above, right) is as follows:

1. Each end of lower counter adjacent to door of patient's room: (a) Horizontally hinged door to bedpan compartment. (b) Horizontally hinged door to dirty linen bin.

2. Service sink with hot and cold water faucet over and locker under.

3. Waste can.

4. Bedpan washer and sterilizer.

5. Instrument sterilizer.

6. Wall above the lower counters: (a) Adjustable shelves for linen, food and medication trays. (b) Combination double jewel bedpan signal and double convenience outlet.

CONSTRUCTION DATA

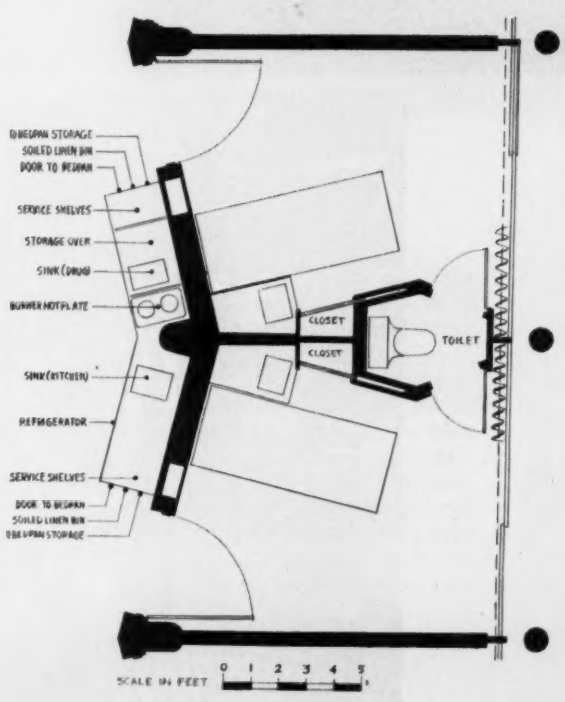
Walnut Creek Hospital

Cost of building	*$1,326,000.00*
Cost of land	*280,000.00*
Cost of equipment (Groups I and II)	*148,000.00*
Bed capacity	*94*
Cost per bed	*14,106.00*
Cost per square foot	*26.00*

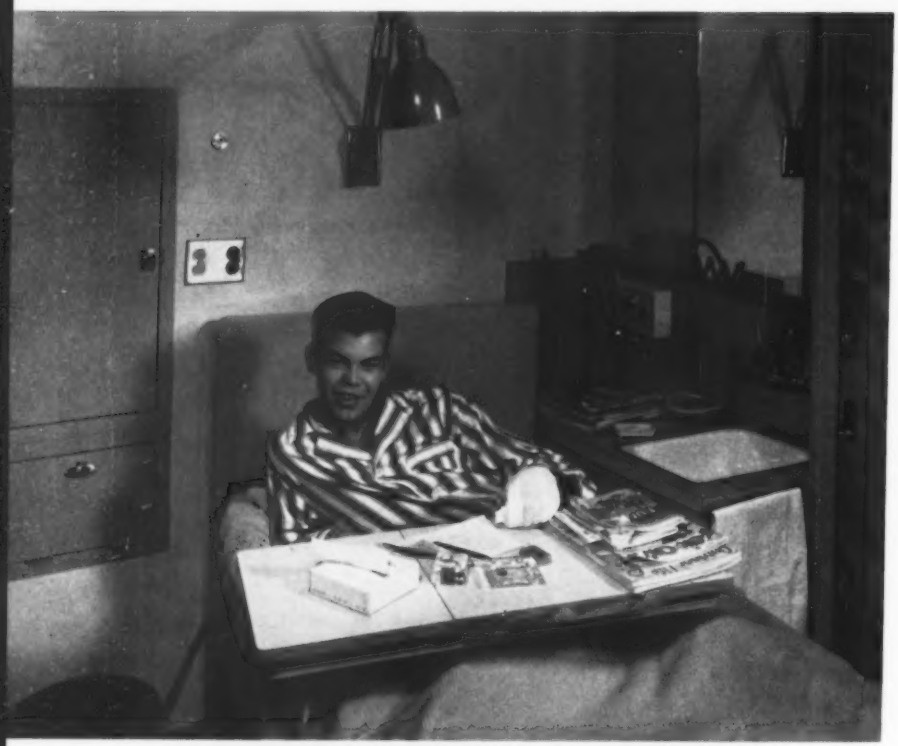
Walnut Creek Clinic

Cost of building	*$ 134,000.00*
Cost of land	*31,000.00*
Cost of equipment (Groups I and II)	*31,000.00*
Cost per square foot (approx.)	*26.00*

TYPICAL LAYOUT OF NURSES' STATION AND DRUG AND KITCHEN UNIT



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by The Modern Hospital each month.



Design of the Single Occupancy Bedroom

Equipment included in a typical general nursing room is as follows (from left to right):

1. Horizontally hinged door to bedpan compartment so that pan is readily accessible to patient. Patient signals the nurse that pan should be emptied by switching toggle on extension control panel.
2. Should the patient crave coffee and toast, he opens the vertically hinged door and finds a two-cup coffee maker and a one-slice toaster which can be plugged into the double convenience outlet.
3. Combined in the same face plate are the nurses' call button and, below it, emergency call.
4. Directly above is a piped oxygen outlet served from the central oxygen supply service.
5. Bedside light can be adjusted to any desired position for reading or making examinations.
6. A telephone can be plugged into jack behind the patient's bed.
7. The telescopic push-button panel enables the patient to select one of three radio stations or phonograph music from a central record player; it also permits the patient to call the nurse or turn on bedpan signal.
8. Window curtain control toggle switch is combined with the double convenience outlet plug. Pushing switch down causes a 1/64 h.p. motor to spin around the curtain rod and open the curtain. Pushing switch up closes curtain; neutral position stops it.
9. Enameled iron sink is flush-fitted into plastic counter top. Below is steel cabinet and behind the towel rack are two sliding steel drawers.
10. Hot and cold water is supplied by a mixing valve.
11. Ice water fixture.
12. Mirrored cabinet holds toilet articles: brush, comb and so on.
13. Behind the sliding wood door is a small clothes closet.
14. Overbed table.

Below: Floor to ceiling and wall to wall aluminum and glass sliding doors on the lanai side of the room. Ceilings are acoustical plaster; floors, gray vinyl tile.

Design of the Maternity Department

As in the general nursing wings, the maternity wing corridor (top right) breaks down into nursing units of eight beds served by one nurse. Each nursing unit is made up of the nurses' station, drug and ktichen unit, and utility unit. Equipment of these areas is similar to that listed for the general nursing wing. The great difference is that a private nursery has been placed between the mother's room and the nursing and utility corridor.

The private nursery (not shown) is fully equipped with everything needed for the care of the newborn infant, from weighing scales to piped-in oxygen. The baby's bassinet, located near the door of the nursery, is of plastic and of the same size as the standard nursery bassinet. It rests in a steel drawer built into the soundproof wall between the mother's room and the nursery and may be pulled to the mother's bedside or pushed back into the nursery. Under the bassinet drawer is a sealed compartment into which a tray drawer with a stainless metal pan insert for dirty diapers slides. Pan can be removed through a drawer located in the work corridor. Clean diapers and other supplies are stored in a steel drawer located under the dirty diaper tray.

The nurse can observe the infants through safety glass observation windows which surround each nursery — similar to those used in the pediatrics department shown at the right.

(*Continued From Page* 62)

Each nursing unit is made up of three primary plan patterns: nurses' station, drug and kitchen unit, and utility unit.

The nurses' stations are placed on either side of the corridor directly opposite each other and in a center position to the bedroom served. The nurses' stations on either side of the corridor have similar equipment except that Nurses' Station A has two x-ray viewers, whereas Nurses' Station B has an intercommunicating system speaker, nurses' call system buzzer, and pneumatic tube station.

Alternating with the nurses' stations down the length of the corridors are the drug and kitchen units and the utility units which occur opposite each other.

In designing the single occupancy bedrooms, Dr. Garfield has incorporated many progressive ideas to improve patient care by increasing the efficiency of the nurse. The self-service and labor saving devices make the patient's hospital stay more comfortable and pleasant and at the same time release the nurse for purely professional activities.

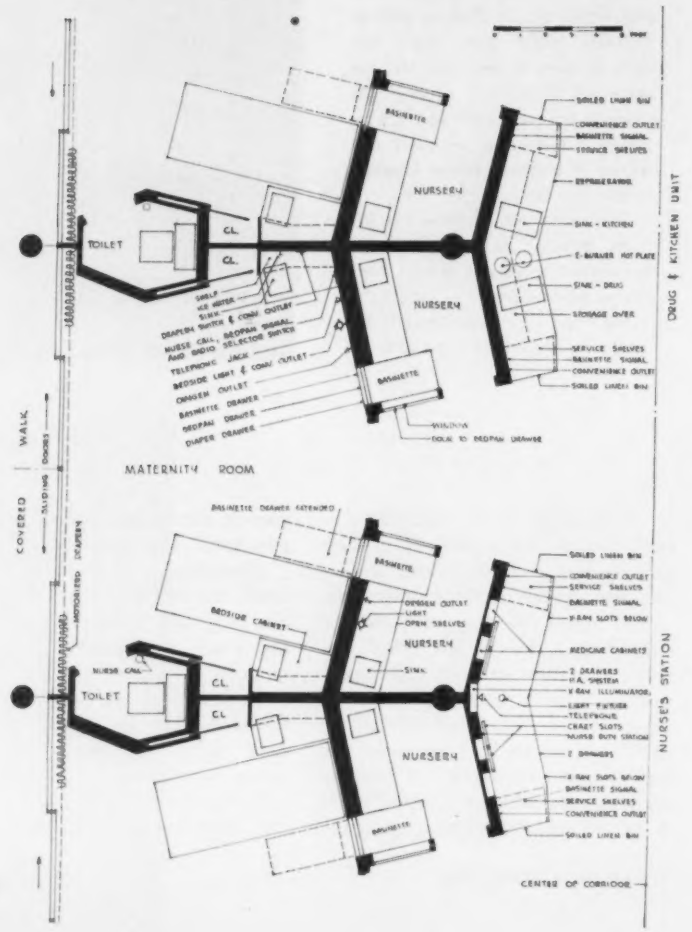
The plan of the maternity department makes it possible to keep mother and the newborn baby close together. It adopts the best physical and psychological features of the "living in" plan, under which the mother is always with her baby; yet it permits the child to be returned to the nursery when the mother wishes to rest. It permits su-

Equipment of Maternity Room

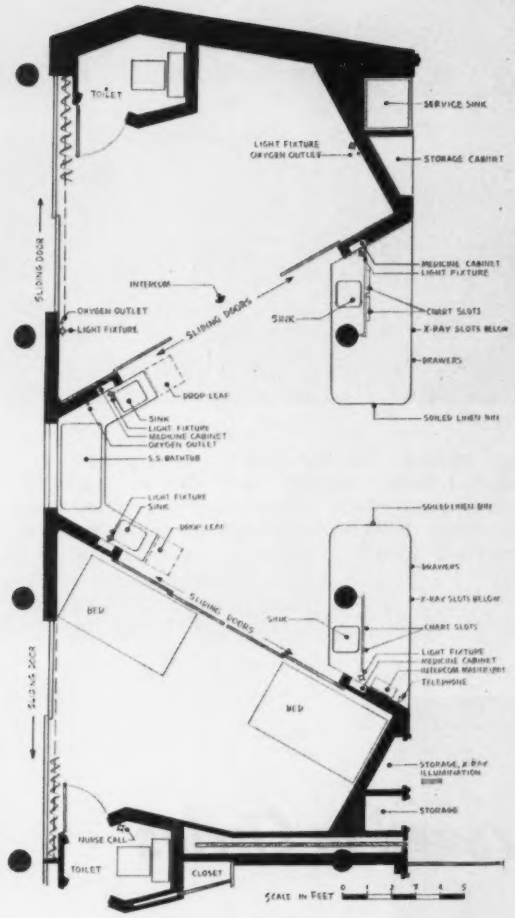
The mother's room contains most of the self-service aids listed for the general nursing room. In addition, there is the bassinet drawer which permits the mother to care for the infant. When the bassinet is pushed back to the nursery, a light automatically signals the nurse to take charge. Note baby's bottle set in an electric warmer, plugged into double convenience outlet.

During visiting hours the father can get acquainted with the infant since the bassinet can be pulled into the room at any time, as long as hospital regulations permit. Other visitors are permitted to view the infant through the glass of the observation window at the mother's bedside.

TYPICAL BEDROOM IN MATERNITY WING



TYPICAL BEDROOM IN PEDIATRICS WING



Layout and Equipment of Pediatrics Department

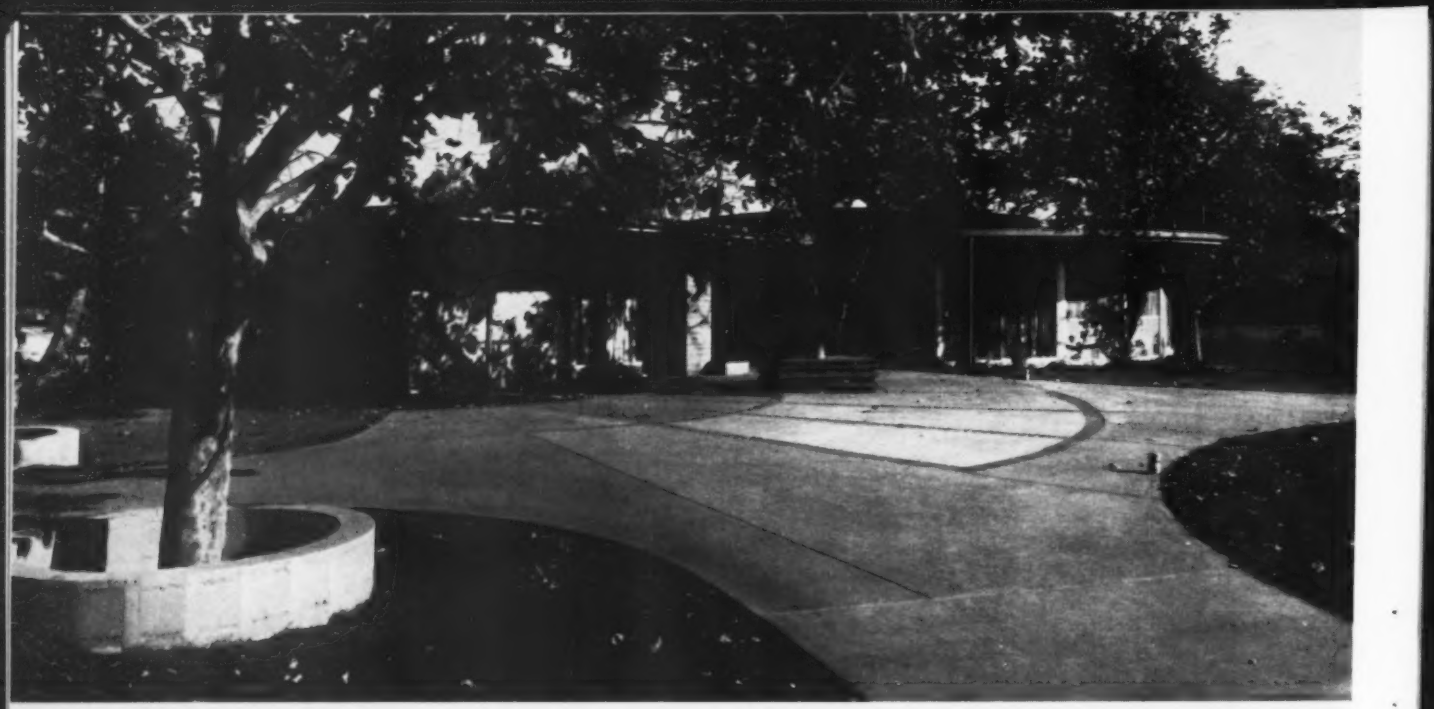
The pediatrics section is located at the end of the corridor of the general nursing wings. Here, the nursing and utility corridor is a diamond shaped room surrounded by four double crib rooms. The rooms are separated from nurses' work area by sliding aluminum and glass door. A typical nurses' station is made up of a horizontally hinged dirty linen bin, a bank of storage drawers, vertical slots for x-ray envelopes, slots for patients' chart holders, enamel iron sink set flush in plastic-topped counter, charge-a-plate imprinter, telephone, intercommunication system and nurses' call speaker connecting to each of the crib rooms. (See also photograph bottom, right on page 67.) Above: A patient is about to have his teeth brushed at the counter-high sink.

pervised training of the new mother to care for her new baby properly and with confidence. Cross-contamination is minimized by elimination of the community nursery.

The mother aided by the maximum use of self-service and labor saving design and devices has released the nurse from many time consuming details so that the majority of her nursing time can be devoted to patient care. Every possible effort has been made to cater to the happiness and well-being of mother, child and father during this important period in their lives.

The plan layout of the delivery, central supply, surgery, emergency and x-ray areas received favorable comment from many of the architects and hospital consultants attending the 1953 national convention of the American Hospital Association held in San Francisco.

An existing building connected to the new hospital by an aluminum covered way has been remodeled to house the nurses' dining room, doctors' dining room, kitchen, storerooms, male and female employes' locker rooms, and living quarters for the resident intern. The food is served hot to the rooms by means of electrically heated bulk food carts. There is no laundry room or large linen storage room as the laundry is done at a central location in the near-by city of Oakland and is delivered daily to the several Foundation Hospitals in this area by truck.



Above: Curving concrete and brick walkways from the parking area, highway and hospital meet at the entrance of the Walnut Creek Clinic. Photograph at bottom of the page shows the heavy structural glass doors of the entrance, plate glass side lights and transom. The high and low brick planters extending through the side light make an interesting architectural effect. This photograph, taken from the lobby, looks south through the entrance to the maternity wing.

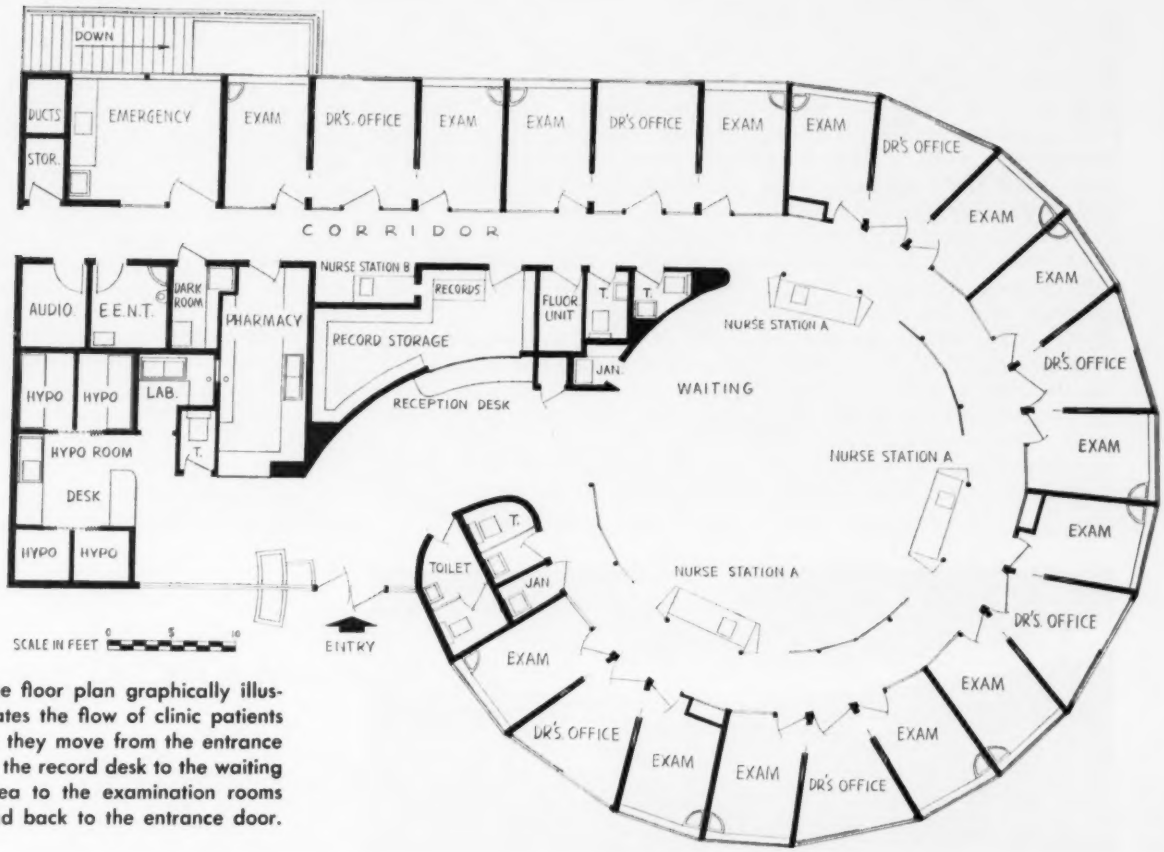
At Walnut Creek Clinic

Ambulant Patients Go Around in Circles

AS PART of the Kaiser Foundation Medical Center at Walnut Creek the clinic has been designed as a separate detached building placed in a garden setting between the hospital and the parking area to the north.

As he did with the hospital, Dr. Garfield set the plan pattern. His suggestion of the unusual circular plan was the direct result of studying a diagrammatic flow pattern of a typical clinic patient as he moved from the entry door to the record desk, to the waiting area, to the examination rooms and back to the entry door. It seemed logical that a circular plan would accommodate these movements just as well as, if not better, than the more

(*Continued on Page* 72)



The floor plan graphically illustrates the flow of clinic patients as they move from the entrance to the record desk to the waiting area to the examination rooms and back to the entrance door.

Top, right: This photograph shows the circular clerestory element with its plate glass set with butt joints and center plastic dome which lights the interior waiting area. Bottom: Patient at the record room counter. Records are stored in vertical file bins. After directing the patient to the waiting area receptionist, the attendant takes the patient's file from the bin and sends it to the proper nurses' station through the pneumatic tube system. In the upper left hand corner is the waiting area that services the pharmacy, hypodermic clinic and specimen laboratory.

conventional clinic plan. Mr. and Mrs. Henry J. Kaiser approved of the experiment and much of the preliminary planning was done in their living room, chairs, tables and sofas being used to mock up the wedge shaped doctors' offices and examination rooms which resulted from the circular plan.

As the floor plan shows, the record room has been conveniently located off the lobby directly opposite the entrance doors. To the left is the waiting area that services the pharmacy, hypodermic clinic and specimen laboratory. To the right is the circular waiting area that services the doctors' examination rooms. A patient entering the lobby walks straight ahead to the record room counter. Here he announces himself to the record attendant, and is directed to the reception desk located in the center of the circular waiting area. Here the receptionist directs the patient to the proper waiting space such as "medical appointment," "medical drop-in," "surgery" and so on.

In the meantime the record attendant has taken the patient's record from the files and sent it by means of the pneumatic tube system to the nurses' station serving the waiting space to which the patient has been directed. In this way the patient and his file are brought together at the proper waiting space. The nurse in charge of the nurses' station gives the record to the doctor and directs the patient to an examination room located on either side of the doctor's office. The nurses' stations, together with wood screens, separate the waiting area from a circular corridor that services the doctors' offices and examining rooms.

In general, each doctor is allocated an office and two examination rooms. This unit forms the basic plan pattern. However, the use of the examination rooms is considered flexible so that the busy doctor can use more than his two assigned rooms.

From her desk in the middle of the circular waiting area (top), the receptionist is able to direct the patient to the correct section. Directly behind the reception desk is a typical nurses' station which serves two waiting sections. In between the nurses' stations are wood screens that separate the waiting area from the circular corridor that services the doctors' offices and adjoining examination rooms. Bottom: Details of the corridor side of the nurses' station. From left to right, the elements that make up the unit are: (a) Plastic covered writing counter. (b) Paper towel cabinet. (c) Soap dispenser. (d) Overhead storage cabinets. (e) View porte overlooking waiting section. (f) Fluorescent light. (g) Plastic covered work counter with sink, hot and cold water faucet, drawers and locker underneath. Pneumatic tube carrier can be seen on the counter.

Aerial view of the Larue D. Carter Memorial Hospital, Indianapolis.

Larue D. Carter Memorial Hospital

Indiana's New Approach to Mental Illness

JUUL C. NIELSEN, M.D.
Medical Superintendent
Larue D. Carter Memorial Hospital, Indianapolis

THE Larue D. Carter Memorial Hospital of Indianapolis admitted its first patient July 28, 1952. Less than a month later she was improved and was discharged. Therein lies the story of Indiana's new approach to mental treatment, based on bringing about rapid recovery wherever possible instead of lengthy custodial care. The need for intensive care, designed to treat mental illness quickly, and to train personnel to administer such treatment provide the twofold purpose of Carter Hospital.

Carter not only attempts to fill some of the crying needs for intensive and early treatment of mental patients, but also trains doctors, nurses and other professional personnel and attendants so as to make more trained personnel available for the state mental health program.

For the most part, Carter attempts to accept patients it can reasonably expect to return to society as useful citizens in from 60 to 120 days or less. Admission to the hospital is by voluntary application of the patient on recommendation of the physician and by temporary commitment by a circuit court on recommendations of two physicians who are residents of the county where the patient is located.

The hospital, with an ultimate capacity of 250 beds, is designed as the hub of Indiana's mental health program. Operated by the Indiana Council for Mental Health as a state institution, it nevertheless is educationally a part of the Indiana University School of Medicine and is located at the Indiana University Medical Center.

The late Dr. Larue D. Carter, for whom the hospital was named, was first president of the Indiana Council for Mental Health. He was professor of neurology at Indiana University School of Medicine, and chief of the neuropsychiatric department of the Indianapolis City Hospital.

Carter Hospital was constructed at a cost of $4,653,440, or $18,601.76 a bed. It is designed eventually to accommodate 100 men, 100 women, and 50 child inpatients, in addition to handling outpatients, another phase of the new concept of treating mental illness.

The building was planned by Robert Frost Daggett and Associates, Indianapolis architects, with an eye toward meeting the unusual requirements of a new type of mental institution. Because of the length and size of the building, it is constructed as six separate units connected by joints which allow for the expansion and contraction of the concrete. The V-shaped wings, patients' wards, are designed to provide light, sunshine and ventilation for the patients and at the same time offer privacy by preventing them from looking into one another's windows. The floor plan also conveniently segregates the sexes and separates the patients' living quarters from the hos-

pital's administrative, personnel and service areas.

The central section of the hospital houses laboratories, physicians' offices, dining rooms and kitchens, auditorium and lounges. The T-shaped front building accommodates reception areas, administrative offices, conference and classrooms, council offices, and living quarters for the superintendent and his assistant, interns and nurses.

In the matter of interior decoration, it was decided to make Carter Hospital as warm and homey and as little like the usual mental institution as possible. So pastel tints of green, tan, gray, coral and blue are utilized on the walls both for attractiveness and therapeutic value. Sand beige acoustical tile ceilings and tan, gray, red and green marbleized rubber and asphalt tile floors serve the double purpose of reducing noise and blending with the decorative scheme.

Interior design varies somewhat through the wards and other hospital areas, of course, so as to be as functional as possible. Walls are finished in glazed block tile and the floors are terrazzo. Semidisturbed, disturbed and children's wards and most of the basement are finished in this style, with green walls in the semidisturbed ward and tan in the other areas.

Hospital furnishings presented a two-sided problem. Metal beds and some other furniture pieces for wards and administrative service areas were made and supplied to us by the Indiana State Penitentiary, thus effecting considerable saving to the state. There were many items, however, which were essential to our hospital and which the state did not make. Hence, we had to make our own decision in purchasing furniture for lobby, waiting rooms, interns' lounges, snack bar, and patients' library and living rooms. In addition, we wanted each patient to have a comfortable, upholstered easy chair, another thing not made at the penitentiary, for his room. We weighed whether to purchase wooden or metal furniture and finally decided metal would be stronger and less susceptible to damage by patients. We wound up buying metal furniture for all areas not equipped by the penitentiary.

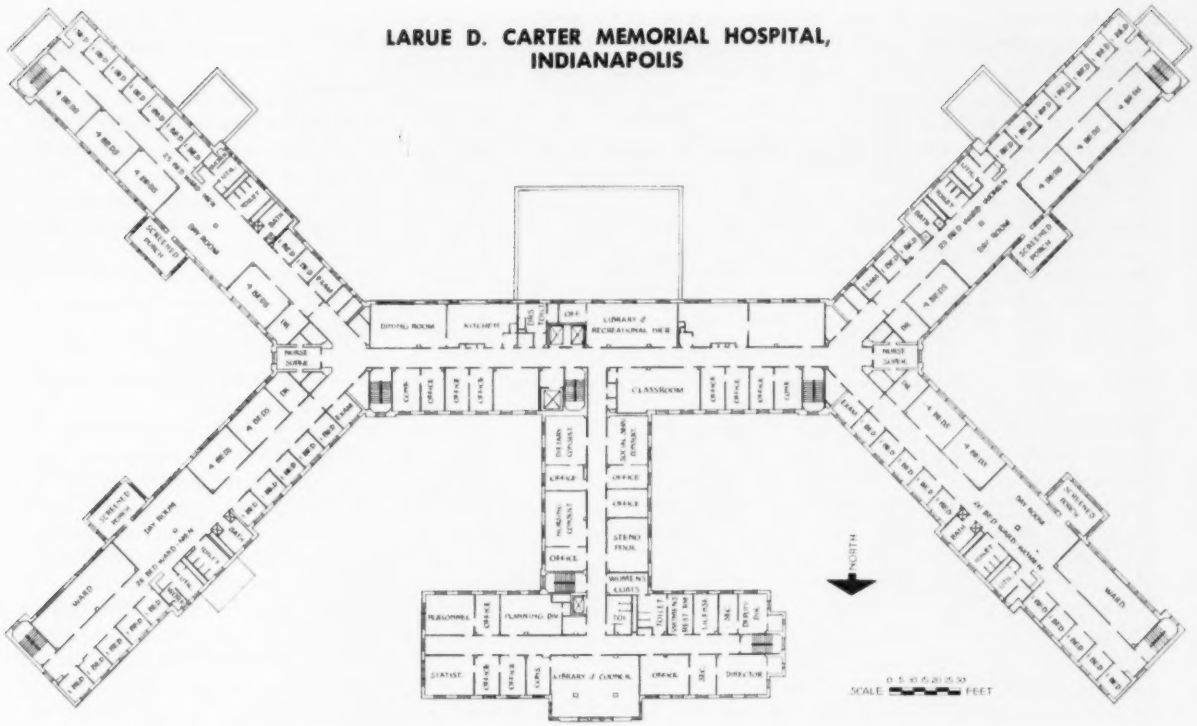
Inpatients' wards, which have both private and four-bed rooms, are furnished somewhat differently, depending upon the type of patients being treated. The least disturbed patients each have a bed, chair and clothes closet made at the penitentiary, and an upholstered armchair we selected.

Patients in the most disturbed section have no chairs and use clothes lockers recessed in the corridor wall. Those in the semidisturbed ward have wardrobe closets in their rooms. Other-

(*Continued on Page* 76)

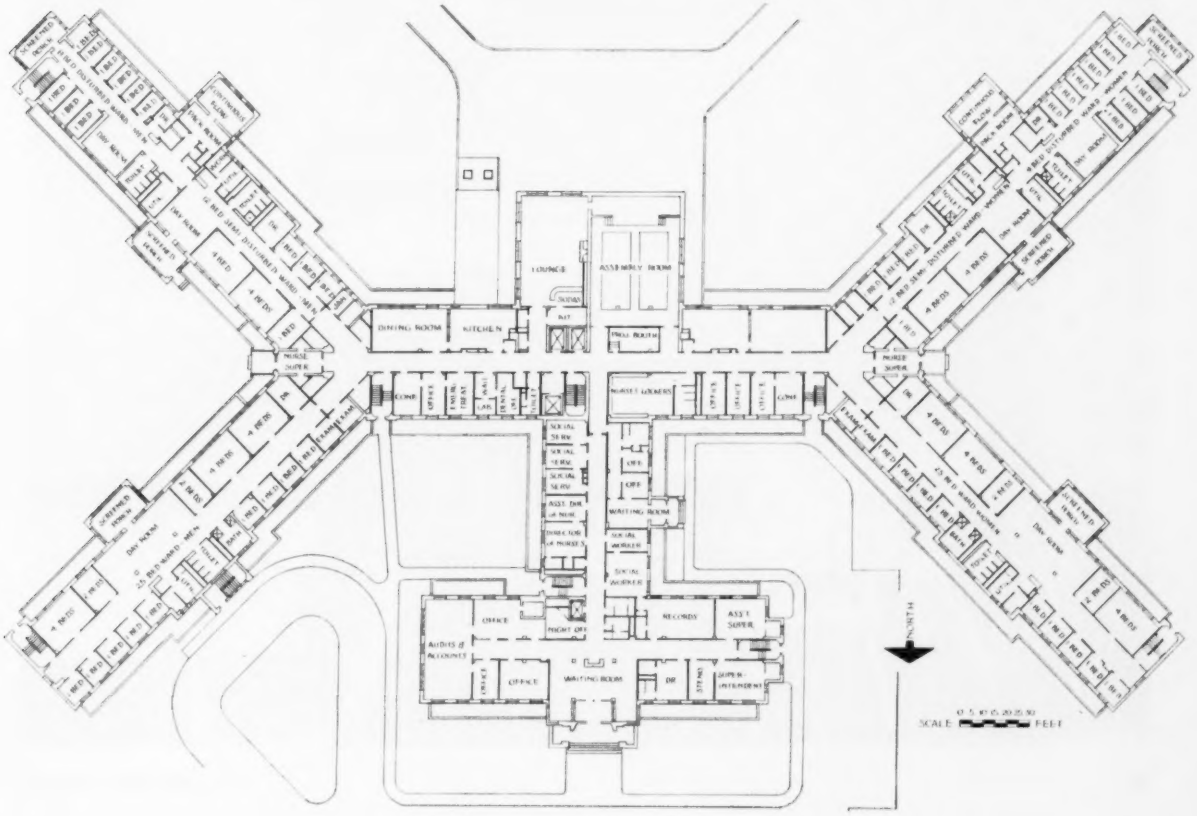
Above: Each patients' ward has a living room such as this one, equipped with modern, comfortable metal furniture. Right: Typical two-bed room. Each patient has an upholstered metal armchair and a metal bed. In addition, each room is furnished with cabinets and wooden side chairs.

LARUE D. CARTER MEMORIAL HOSPITAL, INDIANAPOLIS



Below: Plan of the main floor, which includes administrative, nursing and social service offices, auditorium and lounge for patients, and dining room for personnel. Patients are housed in the four wings.

Above: Classrooms, offices and a library for patients, as well as patient accommodations, occupy the second floor. Each ward has a dining room where patients are served cafeteria-style.



wise, the furnishings are the same as those in the least disturbed.

Each ward has its own living room, equipped with upholstered settees and chairs, tables, smokers and a wall clock —something which is found much too infrequently in most hospitals. There is a screened-in porch off each ward living room.

Puzzles, games and ping pong equipment in these living rooms help provide entertainment in an area which we have tried to make particularly homelike. These and such other things as the easy chairs in the patients' rooms are small but integral parts of the hospital's over-all effort to make living conditions closer to normal for the mentally ill. Certainly no hospital is just like home, but any conveniences the patients can be given are definite aids in assisting the sick of mind.

A patients' library, beauty and barber shops, snack bar and auditorium, occupational, recreational, and physical therapy facilities, special dietary system of cafeteria-style feeding with good food, and psychiatric social service—all are included in Carter Hospital's design for helping mental patients return to more normal thinking and acting.

The second floor library, for instance, is well stocked with a variety of reading material to reach the interests of as many patients as possible. This library, decorated with cheerful draperies and green floor and walls, is comfortably equipped with reading tables and chairs as well as lounge furniture, and also has a corner room for record-playing.

The occupational and recreational therapy division in the basement is well equipped to assist the patient in any program outlined by hospital physicians. It provides treatment by means of participation in occupations or activities devised to attack specific problems on an individual or group basis.

Patients spend from two to four hours in occupational therapy during the day and also have a recreational activity program six nights a week. There also is an occupational therapy program in each ward for patients who cannot participate in regular activities.

Creative and manual arts, industrial, musical and home arts therapy are included in the program, with a special shop and teacher planned to assist in educational therapy for child patients. Weaving looms, jewelry and basket-making workshops, leather and woodworking equipment, typesetting supplies and a small hand printing press, oil and water color paints and charcoal drawing materials, ceramic pottery wheel and kiln all are among the occupational therapy facilities.

Additional facilities designed to make the patient feel more at home in the hospital include a large clothing storage room in the basement, where each patient has his own extra closet

The handsomely equipped snack bar with artificial fireplace, shown at left, is a cheerful meeting place for patients, staff and personnel.

Occupational and recreational therapy division provides a vital part of the treatment of patients. Weaving looms (left) and paints (right) are part of the equipment of this area of the hospital.

to place out-of-season wearing apparel, and a sewing and laundry service. Each patient's storage closet has enough hanger and drawer space for an exceptionally large supply of clothing and is so constructed that no patient's apparel touches any other's.

The dietary department, under the direction of Arlene Wilson, a member of the Indiana University staff, is considered another part of therapy at Carter. Proper diets of nutritious food served in pleasant surroundings can do much to aid the patient's mental attitude. And, except for a few on special diets, the patients eat the same food as the staff. Miss Wilson, who teaches students in psychiatric food service in addition to directing Carter's four finishing kitchens, has installed cafeteria-style feeding, another innovation in mental treatment. This type of service gives the patient an opportunity to make a choice of food, Miss Wilson points out, and that means he is making a decision and getting closer to his normal self.

Food used at Carter is furnished by a main commissary of prepared foods, which serves the Indiana University Medical Center hospitals. It is sent to Carter's four finishing kitchens—one in each ward and one on the main floor for personnel — through a connecting tunnel in heated food carts.

In keeping with the latest psychiatric methods, Carter also has extensive outpatient facilities. The theory of outpatient treatment is preventive psychiatry, an effort to evaluate and treat the patient's mental problems during the earliest stages of their development and without hospitalization.

The basement outpatient ward has its own reception room and outside entrance, enabling patients to enter and leave directly and avoiding the main hospital areas. Resident and other professional persons in training at Carter will work with the outpatients, helping them and at the same time getting experience which will aid in early detection of the symptoms of developing mental illness.

Offices for psychiatrists, social workers, psychologists, and others working with the mentally ill, as well as complete facilities for mental and physical examinations, are included in the outpatient department. It is hoped that outpatient treatment, working with the patient and his community associates, eventually will decrease need for hospitalization because of mental illness.

Carter Hospital also has a psychology department which offers services in psycho-diagnosis, education and research. Various psychological tests are used to discover the underlying dynamics of the patient's efforts at adjustment, providing a valuable aid to the psychiatrist in planning treatment.

In addition, the department carries on research oriented toward improvement of present diagnostic technics and a better understanding of the determinants of a patient's behavior. It also cooperates with Indiana University in training clinical psychologists at the intern level.

The hospital medical staff at full force will include superintendent, assistant superintendent, clinic director, neuropathologist, chiefs of outpatient and children's departments, psychiatric physicians-in-residence, and intern rotation.

The permanent medical staff prescribes the treatment for each patient. It also conducts the treatment and supervises other members of the professional staff in its application, assists in training nurses and other workers in treatment procedure, and gives psychiatric training to medical residents-in-training and interns.

All phases of Carter Hospital—program, personnel, facilities—thus are pointed toward the success of its fight against mental illness: quick recovery and rehabilitation of patients and the best training possible for those whose responsibility it is and will be to help institutions throughout Indiana treat the sick of mind.

A Modern Hospital Round Table

Insurance Brings Problems With the Payments

WITH the constantly increasing number of hospital patients who have Blue Cross or some other form of hospital insurance, the problems associated with handling various forms of insurance have become increasingly important to administrators. To bring some of these problems into focus, Everett W. Jones, vice president of The Modern Hospital Publishing Company, held a round table discussion with three Memphis administrators. The group included Frank Groner, Baptist Hospital; James M. Crews, Methodist Hospital, and Robert C. Hardy, John Gaston Hospital.—ED.

MR. JONES: I gather from conversations here and elsewhere that one of the major administrative problems these days is handling patients covered by either Blue Cross or commercial insurance. What's happening?

MR. CREWS: About two weeks ago, our office manager called my attention to a great increase during the past 90 days or so in patients being admitted with some kind of hospital insurance coverage.

MR. JONES: Let me ask a question: Was the increase in these patients having some kind of insurance greater among those holding Blue Cross than among those having commercial insurance?

MR. CREWS: No, it was just the opposite. By far the greatest increase was in patients having commercial insurance coverage.

MR. JONES: What's the situation at Baptist Hospital? Do you also find that there are more admissions of commercial insurance policyholders than of Blue Cross members?

MR. GRONER: Yes. Commercial insurance companies got a strong start here in Memphis long before we organized a Blue Cross group in this state. This accounts for the fact that at the present time more of the patients in all hospitals in Memphis are covered by commercial than by Blue Cross policies. However, Blue Cross is stepping up its efforts, its popularity is growing, and I am confident that in the not too far distant future Blue Cross will pass the total coverage of all commercial companies.

MR. CREWS: What's the situation in a city hospital? Do you have any great problem because of increasing numbers of patients covered by some type of hospital insurance?

MR. HARDY: Until recently we haven't had very many patients come into our city hospital with any kind of insurance coverage. We are a charity hospital and have very few paid patients. However, a short time ago the city of Memphis took out Blue Cross coverage for all of its employes. As a result of this we have noticed in recent months an increase in the number of people coming into the hospital with insurance coverage. In our particular case the majority of those who are so covered have Blue Cross.

MR. JONES: Does this mean that you're beginning to get some patients who would have been eligible for free hospitalization as medical indigents if they had not had Blue Cross?

MR. HARDY: Yes, that's right. A lot of these patients are colored, and many of them would really be borderline medical indigent cases. However, since the city now has them all covered with Blue Cross, we are able to collect our approximate cost. If they didn't have Blue Cross we would have received nothing. Furthermore, as Blue Cross and commercial insurance coverage increases in this area, I'm sure that the number of patients for whom we can get no payment will decrease, and the number of patients for whom we will get approximate costs because of their Blue Cross coverage will increase. This, of course, will mean an improved financial picture for our city hospital.

MR. JONES: Would some of the people who come to Methodist Hospital with insurance coverage have been medical indigents, or outright relief patients, if they had no kind of insurance coverage?

MR. CREWS: Well, I'm not so sure about that. I know that has always been an argument, but it has yet to be proved to me.

MR. JONES: What's the situation at Baptist Hospital?

MR. GRONER: We haven't made a thorough study of it, but I'm reasonably certain that many of our patients who have some type of insurance coverage would have been ward service patients, with the hospital getting considerably less than its cost per day.

MR. JONES: Have you ever thought of taking a large group of consecutive admissions of patients having Blue Cross and analyzing these cases from the social service and credit standpoint, to see what economic category they would have been in if they had not had Blue Cross?

MR. CREWS: We've never done this, and I suppose some time we should. However, I'm not at all certain that we'd find such a good picture as you suppose.

MR. GRONER: From some limited studies we've made we know there are

Participants in the round table on insurance problems, from left to right: Frank Groner, Everett W. Jones, Robert Hardy, and James Crews. The three administrators are all from Memphis.

a considerable number of patients with either Blue Cross or commercial insurance, from whom we get a greater income than we could possibly have if they did not have insurance. These people are in the borderline, medical indigent group. However, we have an offset to this. There is a considerable number of patients who feel that because they have insurance coverage, they do not owe the hospital anything. Some of these people are well above the medical indigent classification, and would be paying their entire bills themselves if they didn't have insurance. They feel that because they have hospital insurance, their bill should be completely covered by this insurance, and therefore they shouldn't have to pay the hospital anything. We have some bad debt losses from this type of patient, and these losses offset the gain from patients who might not have paid us if they hadn't had hospital insurance.

MR. JONES: I think hospital administrators and their credit officers sometimes forget the intensive, expensive efforts that the hospital must put forth to collect the bill. The over-all collection expense is considerably decreased as the percentage of population having insurance increases.

MR. GRONER: I wonder if too many of us are not overlooking another socially significant factor, and that is that with the growth of insurance, many people are able to come to the hospital just as soon as their physician advises hospitalization, instead of waiting, and sometimes having their illness grow more severe, all because they have some kind of hospital insurance.

I think we must give Blue Cross a great deal of credit for its pioneering work in making it possible for people to budget or to prepay their hospital care costs. Certainly, Blue Cross pioneered in this movement, and the commercial insurance companies have only in the past few years climbed on the bandwagon.

We must recognize that many borderline people don't have any excess money, and therefore they are inclined to try to avoid paying the balance of the bill which is not covered by their insurance policy. By and large, we have more trouble with the patient who is covered with commercial insurance than with those covered by Blue Cross. However, it's a problem in both cases.

MR. JONES: What happens when one of these borderline financial patients gets into the hospital with some kind of insurance coverage, but it's obvious that he can't pay a private doctor? How do you handle these patients? Do you put them on ward service?

MR. CREWS: We put them on ward service, and they are taken care of by our residents and interns and the attending men who happen to be on duty at that time.

MR. GRONER: It seems to me this is the type of problem which cannot be covered by a stated policy. These patients must be considered as individual problems, and must be checked by social service and perhaps the credit department, to see whether they should be assigned to a private doctor or put on service.

MR. CREWS: There is always a problem involved, and it is difficult to give an exact answer as to whether a patient should or should not be under the care of a private doctor. We attempt to determine what the situation is, and if it seems fairly obvious that a patient can afford to pay a private doctor, we assign that patient to the attending physician who happens to be covering the particular service, caring for indigent patients, at that time. This gives all such doctors a fair share of private patients from this source.

MR. JONES: I think that the hospital has a definite responsibility to its attending staff to see to it that patients who should pay a private doctor are assigned to a private doctor, and are not allowed to go on service, where they get medical care without paying anything for it. Of course, you don't have quite the same problem in a city hospital. How do you handle the situation when a patient with hospital insurance comes into John Gaston Hospital, who seems able to pay at least a nominal fee to a private doctor?

MR. HARDY: We have a small percentage of private patients who can and should pay a private doctor. However, the majority of our patients, even

if they do have Blue Cross, are unable to pay a private doctor.

MR. GRONER: What do you do with a patient who can pay a private doctor?

MR. HARDY: We try to assign them to the younger men on our attending staff, who are doing the major part of the charity work in the hospital. We feel that these young attending men are entitled to it.

MR. CREWS: The best we can all do is make a fairly careful social service investigation, and then use our own good judgment in deciding whether the patient should go on service or should be assigned to a private doctor.

We must never forget that our first obligation is to get the patients into the hospital and see to it that they get necessary care. The financial consideration and the decision as to whether the case should be a private or service patient are secondary matters. It's my experience that the doctors believe, as we do, that the first consideration is to see that the patient gets necessary care!

This is not to say that the other problems aren't important, too. Our office manager called my attention to the recent increase in the number of patients who have insurance coverage. This has resulted in such a great increase in volume of work that we're going to have to hire at least one extra clerk in the insurance department. Hospital administrators, their office managers, credit managers and others involved in the accounts receivable problem are going to have to do some pretty careful studying of all their procedures in handling third party claims to see just what can be done to streamline the procedures, speed them up, and get the information to the insurance companies more promptly than we do now, so that the patients' claims can be settled. We have a considerable delay in completing forms for insurance companies, for example, because of the doctors' delay in completing the medical record.

MR. JONES: In other words, it doesn't do you much good to speed up the financial information and have it all ready, when the claim then has to lie in the office waiting for completion of the medical records?

MR. CREWS: That's right, although I'll have to admit that right now we also have a delay in getting the financial information together! It seems that we're going to have to speed up the financial information process, and at the same time see to it that the medical record is completed within 24 hours, or at the most 48 hours, of the time the patient leaves the hospital. Perhaps when the doctor's own claim for payment from commercial insurance companies and Blue Shield is held up because he hasn't finished the medical record, he'll be more inclined to get it done on time.

MR. JONES: Isn't it interesting that almost any problem we bump into in the hospital, including the process of getting reports to third party payers on time, gets back quickly to the doctor?

MR. HARDY: I think any hospital administrator would be willing to spend some more money in his accounts receivable department to streamline and improve the reporting of facts to the insurance company, if this would result in getting medical records completed on time!

MR. CREWS: We may be forced to tell patients, "We're sorry, but we cannot complete the papers to send to the insurance company because your doctor has not completed your medical record!"

MR. HARDY: If we have to say this to many patients, the doctors will be affected, and maybe it will help get them to do a better job on medical records.

MR. CREWS: I believe there are a number of things we can do in our accounts receivable routine to speed up our whole claim-filing procedure, and it looks to me as though the great increase in the percentage of population covered by insurance is going to force us to learn how to speed up the handling of these claims.

MR. GRONER: The whole problem is complicated by the large number of insurance companies now writing hospital insurance. We have hundreds of different forms in our office. If the commercial insurance companies themselves, and I mean all of them, would get together and agree on a standard reporting form for the filing of claims, it would eliminate a lot of trouble in our accounts receivable insurance offices.

MR. JONES: I understood that some of the bigger, well known insurance companies had agreed with a committee of the A.H.A. on a uniform reporting form, on which the financial transactions as well as the medical diagnosis and other medical facts were reported in a uniform manner.

MR. GRONER: It is true that a few of the larger companies had a special committee working with the American Hospital Association. However, there are many smaller companies which were not included in this group, and which all have different claim forms to be filled out. Another problem, particularly with the smaller companies, is trying to find out if a patient is or isn't covered, and exactly what benefits the policy covers, so that we know what we must charge the patient. And even with some of the best known and most reputable companies in the country there is a problem. They write entirely different policies for the big, preferred risks—that is, the large groups of employed people in big manufacturing concerns get one type of policy, while the policies they write for smaller groups and individuals are entirely different. Sometimes, when one of these big insurance companies writes a large group employer who has factories all over the country, they begin to want different or additional information on the so-called standardized form. All this adds to our clerical load.

MR. JONES: I'm interested in some of the problems that are going to develop as a result of the recent negotiations between unions and the meat packers. One of these large packers, employing people all over the country, signed up with Blue Cross, and some of the other large meat packers signed up with commercial insurance companies.

MR. GRONER: We're going to have a growing problem on this. As an example, one of the large insurance companies recently wrote a hospital policy covering a company employing people all over the country. The policy provides different benefits in different parts of the country, and it looks to me as though we're going to have to carry hundreds of different forms in our office, to be sure we know just what the benefits are for various companies covered by this commercial insurance organization. If we don't have all the proper claim forms on hand when the patient is in the hospital, we're going to have a terrific problem of tracking down the patient or his relatives after the patient goes home, and after we receive the form from the insurance company. We made an estimate recently, and it looks as though we might have to carry something like 3500 different benefit

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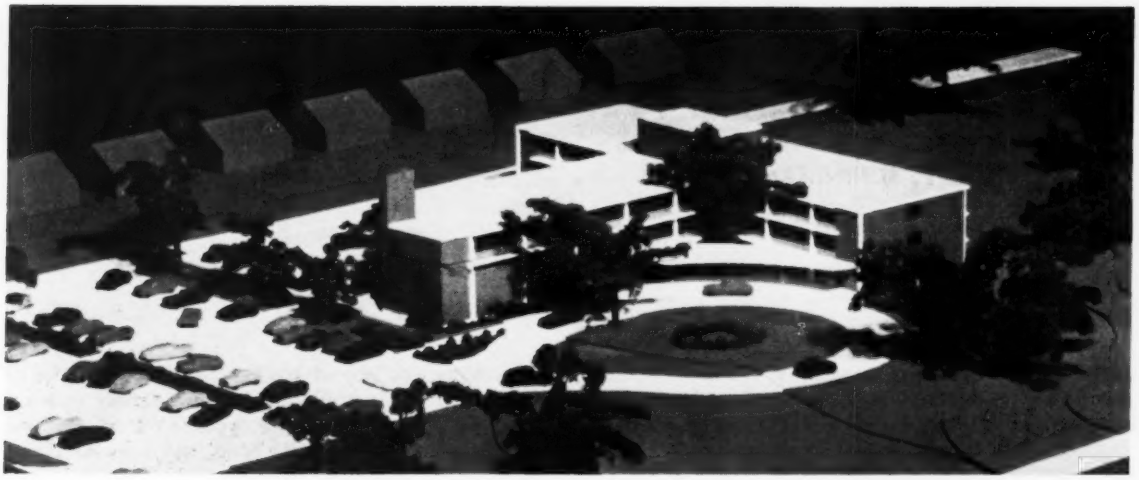
THE MODERN HOSPITAL OF THE YEAR 1953



Fayette County Memorial Hospital, Vandalia, Ill.

THE Fayette County Memorial Hospital at Vandalia, Ill., has been named "Modern Hospital of the Year" for 1953 by a special committee of judges. The committee reviewed plans of hospitals published during 1953 in the "Modern Hospital of the Month" series and selected Fayette County as "Hospital of the Year" on the basis of efficient planning and economy of construction.

The Fayette County Memorial Hospital was designed by Pace Associates, architects and engineers, of Chicago. Dr. Herman Smith of Chicago was the hospital consultant.

Members of the committee making the selection were W. H. Tusler of Minneapolis, a member of the Minneapolis firm of Magney, Tusler & Setter and chairman of the committee on hospitalization and public health of the American Institute of Architects; Frank S. Groner of Memphis, Tenn, administrator of the Baptist Memorial Hospital there and chairman of the American Hospital Association's council on planning and plant operation; Marshall Shaffer, chief of the office of technical services, Division of Hospital Facilities, Public Health Service, Washington, D.C., and Everett W. Jones, vice president of The Modern Hospital Publishing Company.

The Fayette County Hospital, now nearing completion, has 103 beds and was built at a cost of $12,049 per bed. Located in a quiet, residential neighborhood in Vandalia, the hospital will serve a population of approximately 30,000, replacing the privately owned Mark Greer Hospital which has served the community for a number of years.

The hospital plan is a "T" with three stories and basement, and provision for adding 26 more beds in the presently unfinished third floor rear wing.

"This hospital is exceptionally well planned, with every unit functioning in relation to every other unit," Mr. Tusler stated in making his selection. "The emergency operating room is well placed near the operating and x-ray suites, which means efficient operation with the least amount of personnel. Central supply is adequate and well placed. The hospital is exceptionally economical of space, with its 501 square feet per bed. It is designed for easy and economical construction. In my opinion, it is an outstanding hospital and well worthy of being named as 'Hospital of the Year.'"

The hospital was financed with Hill-Burton aid and a million dollar bond issue of the Fayette County Hospital District, in addition to state funds.

In announcing their selection of Fayette County as "Hospital of the Year," members of the selection committee noted that only 10 of the twelve 1953 "Modern Hospital of the Month" projects were considered. The Meeker County Memorial Hospital at Litchfield, Minn., "Modern Hospital of the Month" for March 1953, was eliminated from consideration because it was designed by Mr. Tusler's firm, and the Harlan Memorial Hospital at Harlan, Ky., "Modern Hospital of the Month" for November, was eliminated because many of the hospital's service facilities will be handled through other units in the United Mine Workers' hospital chain, of which it is a part, a factor that affects cost and design to such an extent as to make comparability with other hospitals impossible to judge, in the opinion of committee members.

Quick Credit Check

provides an effective diagnosis of the patient's economic health

R. F. SCHINDERLE
Manager, Business and Admitting Office
St. Francis Hospital, Peoria, Ill.

AN EFFECTIVE diagnosis of a patient's *economic health* is as important to the business office as a diagnosis of his physical health is to the surgeon. Treatment of the patient is prescribed accordingly. This is not only preventive therapy to keep the patient from getting too deeply in debt with the hospital, but it is primarily a public relations program for handling business affairs with the patient in a business-like manner.

There is no reason a patient with an A-1 credit rating should be subjected to a financial third degree simply because he has had to go to a hospital. Furthermore, this policy of extending credit shouldn't be limited to the obvious "Mrs. Well-to-do." There are large numbers of people whose credit records are entirely satisfactory even though they don't happen to be one of the "Four Hundred" or owners of large industrial plants. It is important to show these people the same courtesy that is extended to "Mr. Tycoon."

At the other end of the scale, a patient whose credit record indicates that he may never pay you (at least he doesn't pay anybody else) is certainly not entitled to the luxury of a private room unless it is medically required.

The problem, of course, is to find out something about the financial condition of the patient immediately upon admission to the hospital.

At St. Francis Hospital, Peoria, Ill., we are now using a quick credit check from the Credit Bureau of Greater Peoria. Basically, we give the credit bureau a copy of our admission slip and it furnishes us the file record on the patient. This is all done in a period of 36 hours. Actually, of course, the program is not quite so simple. We have spent considerable time and effort in working out forms and procedures in order to make the program function as well as it does now.

As the plan now works, all the credit bureau's copies of the hospital admission slips for the past 24 hours are mailed to the bureau at 7:30 p.m. each day. (At St. Francis, surgical patients have to be in the hospital by 4 p.m. so any necessary laboratory work can be performed.)

We use an 11 part "snap-out" form for our hospital admission records. We have had to redesign this form several times but it now seems to work quite satisfactorily, with the credit bureau receiving Page 10, which gives all the personal information in regard to the patient with the exception of the diagnosis (this is blanked out on the snap-out carbon).

The credit bureau receives the name, address, age, wife's or husband's name, and employment, information similar to the regular credit inquiry that a department store would use to identify the individual. On the bottom of this copy of the admission slip which goes to the credit bureau there are six numbered blanks. The bureau checks its credit file and then simply makes a check mark opposite the correct number on the blank, and mails the admission form back to the hospital.

Forms mailed from the hospital at 7:30 p.m. arrive in the bureau the next morning, are looked up and mailed back to the hospital that same evening.

The six numbered blanks represent credit ratings as follows:

1. Satisfactory.

In file since ..... Installment and 30 day accounts. Patient has good credit record; has always paid his bills promptly, and no reason to think that he would do otherwise with the hospital.

2. Slow but no litigation.

Patient has always paid bills but not always on the first of the month when they were due. No reason to think that patient will not pay but good idea to make sure that terms and due dates are clearly understood.

Installment buyers are quick to understand installment terms—so much per week or month—and to figure the additional payments in their regular budgets. Incidentally, most installment buyers are now used to paying interest listed as "installment charges."

3. Collections and/or litigations.

Patient already has several collection accounts against him. If he runs true to form, the hospital will probably

have to get its money through some collection procedure, too.

If the collection division of the credit bureau is handling the collections it lists on the form whether or not any of the collections are from St. Francis Hospital. It would note on the form, "See your collection account on John Jones, listing sheet dated 6/2/52."

4. Bankruptcy and/or medical and hospital accounts.

Patient has gone or is going through bankruptcy. If hospital has been listed in bankruptcy, notation of date and amount is made on reporting form: "St. Francis listed in June 15, 1937, bankruptcy schedule—$275.15."

5. No record, no basis.

No. 5 is checked when the credit bureau does not have a file record of the individual and also when the credit bureau does have a record but it is inadequate for making a credit decision. For instance, perhaps the file record shows only one credit transaction for a very small amount and covers only a two or three month period. A young person has just moved to town, obtained a job in a factory, and purchased a few small items of clothing on credit, has no seniority, is renting, and the record goes back only a period of 60 to 90 days.

6. Comments.

This is for the remarks in regard to any of the check marks that might need further explanation. Comments are usually brief. "Newcomer," "we show different employment," and so on.

When the reports come back to the hospital those on which No. 1 and No. 2 are checked are immediately sent to the cashier's office where the number is put on the patient's ledger record with marking pencil. This does not disclose any confidential information if the patient or someone else should see the ledger card. At the same time it gives the girls in the cashier's office information they need.

I handle the cards on which Nos. 3, 4 and 5 are checked; rate them for customer contact, and discuss them with our interviewer. St. Francis is a 600 bed hospital (now building an addition) and averages 21,000 admissions during the year. Under the circumstances, we need a full-time interviewer. He knows from the record what procedure to take. We do not interview the patient unless it is absolutely necessary but talk to a close relative instead. We leave a note at the reception desk to have the receptionist advise the husband (or wife) to come into the business office when he comes to the hospital to visit the patient.

We do not get a credit check on all admissions. We can see no reason to check those who have Blue Cross or industrial insurance which pays directly to the hospital unless the patient requests a private room. Without taking the time to analyze the figures carefully, I would assume that, roughly, we get quick credit checks on 50 to 60 per cent of our admissions.

In working with the program we have noticed one feature which we believe could be incorporated in the plan for the benefit of the patient, the medical staff, and the hospital. This feature is some type of an advance reservation system which could be worked out in detail with the medical staff. We realize it is not always possible to make reservations two or three days in advance. When it is possible, however, reservations could be handled in such a manner that sufficient information could be obtained at the time the reservation is made to enable the credit bureau to make a file check and give us a credit rating on the individual before the patient is admitted. Thus, not only would the hospital have the information at the time of admission instead of 36 hours later, but the doctor, since he receives a complete copy of our admission forms, could also be furnished the credit information we have available. By doing this, we would give the doctor some idea as to what he could expect with regard to payments from the patient, and in all probability we would be able to get the needed cooperation from the staff members in order to make such a program practical.

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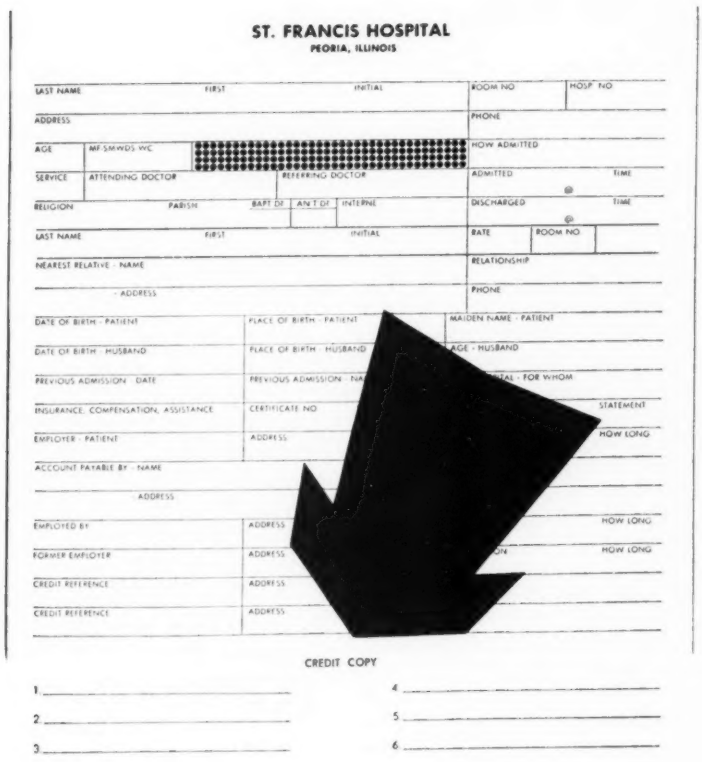


ST. FRANCIS HOSPITAL
PEORIA, ILLINOIS

LAST NAME | FIRST | INITIAL | ROOM NO | HOSP NO
ADDRESS | PHONE
AGE | M F S M W D S W C | HOW ADMITTED
SERVICE | ATTENDING DOCTOR | REFERRING DOCTOR | ADMITTED | TIME
RELIGION | PARISH | BAPT OF | ANT OF | INTERNE | DISCHARGED | TIME
LAST NAME | FIRST | INITIAL | RATE | ROOM NO
NEAREST RELATIVE - NAME | RELATIONSHIP
- ADDRESS | PHONE
DATE OF BIRTH - PATIENT | PLACE OF BIRTH - PATIENT | MAIDEN NAME - PATIENT
DATE OF BIRTH - HUSBAND | PLACE OF BIRTH - HUSBAND | AGE - HUSBAND
PREVIOUS ADMISSION - DATE | PREVIOUS ADMISSION - NA | ...TAL - FOR WHOM
INSURANCE, COMPENSATION, ASSISTANCE | CERTIFICATE NO | STATEMENT
EMPLOYER - PATIENT | ADDRESS | HOW LONG
ACCOUNT PAYABLE BY - NAME
- ADDRESS
EMPLOYED BY | ADDRESS | HOW LONG
FORMER EMPLOYER | ADDRESS | ...ON | HOW LONG
CREDIT REFERENCE | ADDRESS
CREDIT REFERENCE | ADDRESS

CREDIT COPY

1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

The credit bureau receives one page of an 11 part "snap-out" form, which gives all personal data in regard to the patient, except the diagnosis. At the bottom of the form is space for six numbered blanks, which the bureau checks according to its findings as to the patient's credit rating.

As yet we have not had an opportunity to work out the details of such a plan. We do hope, however, that at some future date the necessary changes can be made to make such a program feasible and attractive to our staff.

We made three changes in our "snap-out" admission forms before adopting the one we now use. When we first started to develop this idea with the credit bureau, we simply sent an unprinted carbon of our admission form. The credit bureau, using a rubber stamp, stamped out the six-part form on the back and then checked the proper number.

We have watched this program with great interest and have found the result gratifying. Before we submit our results, however, we feel it is necessary to qualify our actions and indicate the additional steps we took at the time the credit check was originated. Not only did we institute the credit check, but we changed our follow-up procedures considerably. In addition, we insisted on the completion of insurance assignments whenever possible and we instituted a procedure for personal interviews with those patients requesting credit terms. All of the foregoing factors must be taken into consideration in an evaluation of the final result.

To us, the important result has been the increase in our average monthly collections. Specifically, our average monthly collections for the first six months of 1953 were approximately 20 per cent higher than those for the same period in 1951. This increase was accomplished without the benefit of any increase in hospital rates and with a net increase of only 20 hospitalized patients during this six-month period.

Our average patient stay is seven and one-half days. Thus, the quick credit check gives us a chance to interview most patients or the nearest relative before check-out time.

We originally developed this plan through working with the collection department of the credit bureau. After checking some of the credit ratings of persons for whom we had collections it became obvious that much of our trouble could have been eliminated if credit information had been available at the time of admission. We have used it for two years now and it does seem more valuable all the time.

An open letter to the administrator

Why Housekeepers Get Gray

MADGE H. SIDNEY
Executive Housekeeper
Evanston Hospital, Evanston, Ill.

DEAR MR. ADMINISTRATOR:

At the administrative staff meeting yesterday you asked your department heads to economize wherever possible and I feel that I must explain to you why I, your executive housekeeper, cannot cut down on the unnecessary waste of time and materials charged to housekeeping but caused and controlled by hundreds of people: our hospital personnel, both professional and nonprofessional. The auxiliary and volunteers, the unpaid workers, are most considerate but the paid workers (including the medical staff), the very ones who depend on the hospital for their bread and butter and who should take pride in it, are keeping the housekeeping department so busy cleaning up after them that I begin to wonder whether we're working for the patients or the personnel.

If you want proof take a quick look around our buildings and what do you see? A footprint on a newly painted corridor wall, caused by careless personnel, standing stork-fashion during a conference; ink spots on carpets—where else should fountain pens be tested but in a patient's room?

That corridor looks clean and shiny, or it did until a cigaret butt was ground into it by an employe's heel (and right next to a sand urn, too).

And see those dirty, greasy, finger marks around light switches, fuse boxes, doors and even soundproof squares in the ceiling caused by thoughtless employes who forgot to wash their hands between jobs. (In hotels the maintenance men clean up after themselves, but not in hospitals. Why? Why is everyone so careless? Maybe it's because the hospital belongs to the community and not to the individual. I don't know.) And tobacco juice stains, tsk! tsk!

Discouraging, isn't it? Nail polish on upholstery; coffee stains; cigaret burns; floods caused by faucets left on or sterilizers allowed to run over; plaster broken at every turn, which means only one thing, a dented or broken truck cart or wheel chair somewhere in the building. Our hospital certainly is in "artistic disarray" with candy wrappers, empty cigaret packs, flower petals, cotton pads, dropped anywhere (anywhere being more convenient than the waste receptacles provided for each section). You'd think we never cleaned the place, Mr. Administrator, but I know we do, and I know we spend approximately 7 cents of every patient dollar for housekeeping labor and materials. Of course, some of this has to cover work done for personnel, but don't you agree that too much is wasted on unnecessary cleaning and repairs?

Take "gum" for instance—ugly word! We spend hours just scraping gum off the floors. Housekeeping employes are requested not to chew gum and I doubt that any of them even wants to look at gum any more. (Statistics show that office workers prove to be the best gum chewers.)

I could go on and on, showing you at every turn why housekeeping spends so much of the patients' time and money cleaning up after and repairing damage done by careless personnel.

True, we could use more tilt-top trash cans and have them inscribed with the words "Help Keep Our Hospital Clean" and perhaps we could install guard rails to protect the walls, but nothing will really help, Mr. Administrator, until hospital personnel wakes up and realizes that "housekeeping is everybody's business."

Respectfully yours,
Any Executive Housekeeper

Author's Note: The ideas expressed in this letter have been gleaned from the minds of executive housekeepers and it was written with the hope that it will reach the proper readers—all hospital personnel. It was not written to point a finger at any individual or group; we are all guilty in part.—M.H.S.

Among famous San Francisco chefs who help plan one menu a month are: l. to r.: Jack Meyer (Mark Hopkins); Gus Schmidt (Fairmont), Frank Pipia (Fisherman's Grotto No. 9), and Fred Aeberhardt (Rickey's Restaurants) with Gladys Ching, Mount Zion's own chief dietitian.

Arts and flowers—and wine with their meals

They All Add Up to Good Public Relations

HERBERT ABRAMSON
Assistant Director, Mount Zion Hospital, San Francisco

DURING the past year, Mount Zion Hospital, San Francisco, has developed four projects which have made a significant contribution to our public relations program. The first project was the presentation of an art show featuring the art and craft work of employes, medical staff, and other groups associated with the hospital. The other three ideas pertain to the dietary department. A beautiful flower is placed on the luncheon tray served to every patient. For the evening dinner meal, each patient on a general diet is offered the choice of a glass of wine, and each month the chef from a leading hotel or restaurant in the area is invited to plan one meal. These projects have had an enthusiastic response from the community, the press and radio, patients, medical staff, and personnel of the hospital. Some detailed comment about each project will indicate how the ideas were developed and put into action.

ART SHOW

The proposal for an art show was presented at a meeting of the department heads (management advisory council). The outline of a plan which had worked successfully at another hospital was explained. All persons who are directly connected with the hospital, *e.g.* regular personnel, medical staff, student nurses, house staff, and volunteers, would be invited to enter their art and craft work in an exhibit. Such a show would create an excellent opportunity to build up morale among the people at the hospital. Also, by giving appropriate publicity to the exhibit, the attention of the community would be focused on the hospital by a distinctive approach.

The supervisory group was asked to discuss the project with the departmental employes, obtain a rough estimate of how many people do art and craft work, and select a representative from the department for appointment to an art show committee. At the next meeting of department heads, a committee of 12 people was appointed. The group included one department head, employes from the larger departments, a representative of the maintenance department, a student nurse, a doctor on the attending staff, and a member of the women's auxiliary. A few members of the committee had participated in setting up art shows with other community organizations. The committee was organized with a chairman and secretary. Problems discussed at the first meeting were:

1. How many people would enter their art work in the show?
2. What types of work would be submitted and, conversely, what mediums would be acceptable?
3. How many entries should one individual be permitted to submit?
4. Should spouses and children of hospital people be eligible to submit work?
5. Where and when to hold the show.
6. A title for the show.
7. How to finance expenses.
8. Should there be preliminary judging of entries or prizes for the best material?
9. What physical facilities are needed to set up the show?
10. The type of publicity.

Many other questions arose as the plans were developed and refined.

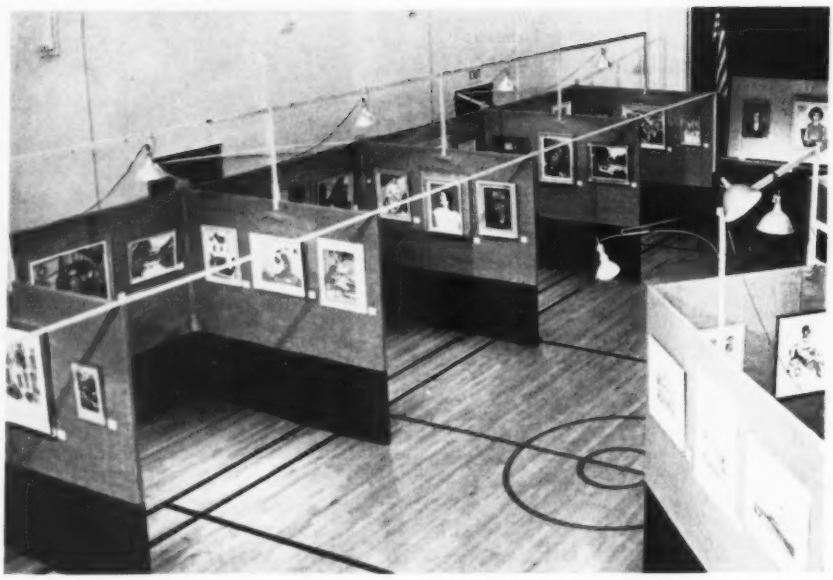
The first meeting of the committee was held in February 1953. The dates chosen for the show were four days in the latter part of May. The spring is often considered a traditionally "arty" season of the year. In looking for a suitable place to hold the show, we had a few specifications in mind: size of the room, ability to lock the area and provide safeguards for the exhibition, amount of lighting, and

accessibility of the room for visitors to the show. Existing lighting is not a limiting factor inasmuch as paintings usually require extra, concentrated lights for proper display in a show. The committee chose the auditorium in the student nurses' residence for the exhibit.

The scope of the show should be clearly defined. The committee decided that the following classes of art and craft work would be acceptable: oil painting, watercolor, pastels, ink drawing, charcoal and pencil, block prints, sculpture, ceramics, wood carving, photography, mobiles, metal work, leathercraft, and weaving. The following types were specifically excluded: needlework, crocheting and knitting. The group also agreed that an individual would be permitted to submit a maximum of two entries in as many classes as desired. The people who were eligible to submit entries were specifically defined. The committee invited employes, medical staff, women's auxiliary, student nurses, house staff, and board of directors. Spouses and children of people in these groups were not eligible.

One of the seemingly intangible elements in planning the first art show is to determine the amount of artistic talent in the organization. In every hospital group there is probably much hidden talent which suddenly comes into the open at the time of an art show. In order to estimate the number of entrants, a preliminary questionnaire was distributed. The form presented the pertinent facts about the proposed show, listed the eligible groups of people, and noted the classes of art and craft work to be accepted. The individual was requested to indicate the number of entries which would be submitted in each class and return the form to a member of the art show committee.

The information derived from this questionnaire proved to be extremely helpful to the committee, particularly in this initial attempt at planning a show. However, the questionnaire will probably not be necessary when the exhibit is produced in future years. The publicity program also started at this time. Some members of the committee prepared colorful posters for display in the hospital. One member designed an attractive symbol which appeared on all the posters and other publicity material. The symbol was a palette with a caduceus running through it, and the title of the exhibit, "Mount Zion Hospital Art Show," written across the palette. The committee discussed the pros and cons of awarding prizes to the best entries and the sale of art work. Judging and prizes were eliminated in an effort to stimulate more entries by the amateur artists. The sale of art work via the exhibit was approved with the understanding that 10 per cent of the sale price would be turned over to the hospital's art show fund to help defray expenses of this and future exhibits. The general expenses for setting up the exhibit were shared equally by the medical staff, the women's auxiliary, and the hospital.



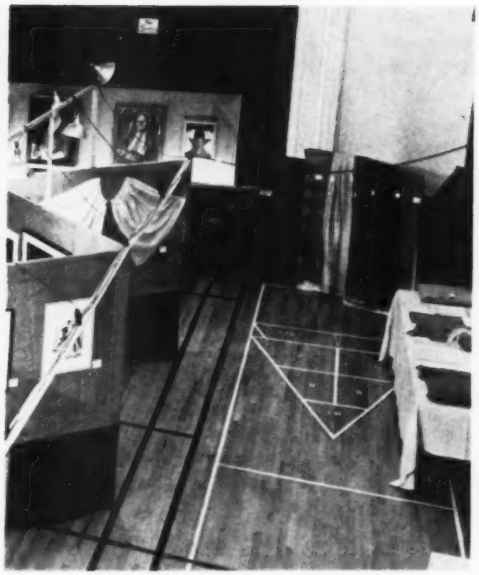
Setting for the highly successful art show at Mount Zion Hospital was the auditorium of the student nurses' residence. The exhibit brought out hidden talent and attracted much favorable comment.

A list of exhibit rules and entry blanks was distributed one month prior to the date for the opening of the show. An outline of the exhibit rules follows:

1. Dates and hours when show will be open.
2. Place where show is to be held.
3. Who is eligible to exhibit art work.
4. Classes of art work (mediums) which will be accepted.
5. Number of entries an individual may submit.
6. Information about the sale of art work, including the fact that any items that were sold were not to be removed until the end of the show.
7. Procedure for submitting entries; where to obtain entry blanks, and when and where to bring the work. We required the entrants to submit the art work in an appropriate manner for display. For example, oil paintings should be framed suitably with screw eyes and wire attached, ready for hanging.
8. Return of art work to artist; when and where individuals should pick up items after the exhibit is closed.

The entry blank requested the following information: title of work, medium, name of artist, hospital department, insurance value, and whether or not the item is for sale. There were also two places for signatures. The person to whom the artist submitted the item would sign for its receipt and the artist signed for the return of the item after the show. The entry blank was written in triplicate. One copy was used by the committee as a reference for typing identification cards which were placed next to each item in the exhibit. The second copy was attached to the art work by the artist. The third copy was retained by the artist.

The maintenance department constructed display panels on legs. Plywood was used, and each panel measured 4 feet high and 8 feet long. The wood was covered with burlap to provide a suitable background for the paintings. Extra lamps were hung to provide more concentrated light over



the paintings. The footlights on the stage gave unusual and excellent illumination to a panel sitting on the stage. A glass showcase was used to display silver work, rings and similar articles. Other items were arranged on tables.

Entries were accepted by the housemother in the student nurses' residence two weeks in advance of the show. When received, the art work was placed immediately in a locked room. An all-risk type of insurance policy was obtained to cover the art and craft work. The chairman of the committee appointed a subcommittee of three members to be responsible for arranging the display. Entrants and others were discouraged from interfering with the work of the "hanging" committee.

The publicity campaign was intensified during the last month. Newspapers, radio commentators, art schools, and other community organizations were contacted. A reception was held on the opening night of the show. Members of the auxiliary graciously served as hostesses throughout the time the exhibit was open.

A total of 74 people submitted 156 entries. The expenses for the show were $260. Practically all the materials used to set up the exhibit can be used again for subsequent art shows. The planning of the show and the exhibit itself engendered a great deal of friendly feeling among the people working at the hospital. Many expressions of cordiality and praise were received from the community. We are all looking forward to the second annual art show.

FLOWERS

I have heard that some dietitians dream of a time when they can place flowers on patients' food trays. The dream became a reality recently at Mount Zion Hospital. The dietary department now places on the luncheon tray served to every patient a complimentary flower and a card with a few lines of poetry. This is done without expense to the hospital or patient. The flower and card are not placed on the tray of a critically ill patient or of other patients where the flower might be inappropriate.

The idea was explained to a florist in the community. We described how the flower would be used to decorate the food tray and make it more appealing to the patient. This would be a positive step in helping to make the patients more cheerful. A proposal was made and accepted to place a tent card by the flower on each tray. The card contains a few lines of poetry which relates to a theme of flowers. The author and title are also given. The name of the florist appears unostentatiously in small print on the side of the card. The florist supplies the hospital with flowers and cards without charge. We receive a delivery each morning, and the type of flower varies from day to day. Twelve basic cards have been printed so that the poetry changes daily. One of the cards has the following lines: *"And then my heart with pleasure fills, And dances with the daffodils."*

WORDSWORTH — *"I Wandered Lonely As A Cloud."*

It may be difficult to evaluate whether or not the flowers have any bearing on a decrease in the number of complaints about food, but the glow in the face of a ward patient is unmistakable evidence that the flowers have earned their place on the menu.

WINE

Another innovation in our food service is the addition of wine to the menu of patients on regular diets. The serving of wine seemed a unique way of improving the menu. The decision to offer wine was reached after careful consideration and approval of the medical staff and the board of directors.

The use of wine in hospitals in the United States seems to have been directed primarily to special diets and nutrition experiments. However, in many parts of Europe, wine has been a staple on hospital menus for many years in company with coffee, tea and milk. Investigators in this country are conducting research as to the possible therapeutic value of wine, and the effect of wine as an appetite-stimulant.

The wine is being furnished to the hospital at a greatly reduced price as a public relations service. No extra charge is made to the patient who desires a glass of wine. Patients have a choice of four types of wine: sherry, sauterne, burgundy, and port. The wine is offered only at the evening dinner meal, and the patient receives about 2 ounces in a stemmed glass. Federal and state authorities were apprised of the plan to serve wine. They advised that we are not required to pay a special tax or to obtain a license. Nevertheless, we do maintain careful control over the receipt, storage and distribution of the wine. During the several months in which wine has appeared on the menu, we have received many favorable comments that the wine helps to enliven the meal, stimulate the appetite, and improve the morale of the patients.

GUEST CHEFS

Each month the chef from one of the restaurants and hotels in the area is invited to plan one meal in cooperation with our chief dietitian and chef. This enables the hospital to offer the patients a more varied and appetizing menu and helps to enliven the meals. The chefs are providing their services without charge and serve in an advisory capacity. The food is prepared by our own dietary staff. Our chief dietitian and chef participated in planning the entire project. This procedure, of course, is most important in establishing a successful program.

Our menus for the special meal give all the pertinent information about the guest chef. In addition, the chief dietitian and chef take the guest chef on a tour of the hospital and introduce him to many patients. The city of San Francisco and the surrounding communities are noted for having an abundance of restaurants and hotels with excellent cuisine. The ones which we have contacted so far have expressed the opinion that the guest chef program offers them an opportunity to build good will and also to perform a community service. This source of outstanding chefs is helping us to improve the food service program in the hospital.

Communications must work both ways

For Best Use of Employes' Time

PAUL J. GORDON
New York State School of Industrial and Labor Relations Cornell University, Ithaca, N. Y.

STAFF members of the New York State School of Industrial and Labor Relations at Cornell University have recently completed a survey of hospitals in cooperation with the Central New York Regional Hospital Council, Inc. Part of the survey was directed toward the very important consideration of the proper utilization of supervisory and employe time. Some of the findings, observations and recommendations have already been published in previous articles in The MODERN HOSPITAL. This article continues with a general consideration of problems connected with communications, turnover and absenteeism.

Delays, misunderstandings, lack of communications in interdepartmental transactions were about the most frequent and universal complaint by hospital supervisors. Major or dramatic cases of friction or of breakdown in communications are few and, therefore, not representative, but minor difficulties are more frequent and more a day-to-day aggravation.

During one of many supervisory conference meetings in an upstate New York hospital, the problem of dirty linen came up. Within a short time, everyone at the meeting was involved in heated discussion of the "linen problem."

The executive housekeeper pointed out that linen was piled up on the patient floors and still awaiting delivery to the laundry at 11 a.m. The laundry manager assured his listeners that the nurses would be crying over a linen shortage on the following morning. The nurses leaped to their own defense, "Why must the linen be down by 10 a.m.? We're too busy caring for patients to attend to linen! The period between 8 a.m. and 10 a.m. is one of our busiest during the day!"

Soon, everyone at the table had suggestions to aid the nurses, including greater utilization of nurse's aides and so forth. To justify his rule of having all linen downstairs by 10 a.m., the laundry manager explained his work schedules, time requirements, and the hours of his employes. Someone asked if the hospital really needed a larger supply of linen and immediately the purchasing agent and the administrator were embroiled.

The administrator pointed out that he could pass the blame to the board of trustees for not authorizing more purchases and they could pass the blame on to the public for not being more generous in supplying money for the hospital. The group then moved in on the linen problem in a constructive way and gained new confidence in one another as they worked together.

Planning for more effective use of the time, the energies, the talents, and the enthusiasm of supervisors and employes eventually leads into a consideration of many phases of personnel administration and human relations.

Looking toward improved cooperation, some department heads who were interviewed in the survey decried the waste of energies expended in trying to answer the question, "Who is to blame?" They thought more solutions and better understanding would result if the energies were exerted to answer the question, "What is to blame?" They seemed to feel that many situations arose owing to lack of being able to fit oneself into the other man's shoes; that better understanding of the responsibilities and problems of all department heads might improve each supervisor's ability to do a better job.

These symptoms may be an evidence of poor communication, even isolation of people at the top supervisory level, and may be worsened by overemphasis on communication "through channels."[1] Hospital supervisors spoke against too much reliance on the impersonal communique, which they felt lacked explanation for the reasons behind instructions. They also criticized too much face-to-face communication where excessive time was spent and no confirming memorandums followed after important instructions or decisions. They tended more to favor some written record of important instructions supplemented by opportunity for discussion when necessary.

Supervisors, in general, expressed the opinion that: "Communication might be improved by more opportunity for free discussion and exchange of ideas on topics such as department head responsibilities, problems, how to increase cooperation, and how to do a better job."

Department heads appear to be in accord in their view that little genuine participation takes place at the usual department head meeting. This they attributed to the structuring of the meeting;[2] to the unequal status and the dissimilar interests of people pres-

[1]Burling, Temple: Effective Communication — Requisite of Good Hospital Care. Hosps. 27:52 (July) 1953.

[2]Structuring here means the grouping of different levels of management as well as different departments.

ent; to the limited time allowed and the irregular basis on which meetings are scheduled, and to the selection of subject matter that does not apply to all departments.

At one series of meetings, the subject for discussion is now the development of a personnel policy manual for supervisors. This move toward greater communication on a subject of mutual concern provides more opportunity for personal recognition to supervisors and benefits to the hospital. The solicitation of opinion, born of long supervisory experience, has apparently transformed discussion-less and exchange-less meetings into a purposeful forum that is producing results with enthusiasm and with full support of the conclusions by conferees.

Another aspect of communications is that within each department. Top level supervisors admitted that more news should filter below the management level, and that insufficient news passed upward on activities, even emergencies, within some of the work groups. A difficult barrier to overcome is that brought about by a variety of shifts and work schedules.

The subject of communications requires further investigation. As a starting point, hospitals might reexamine written communications to test their readability and the degree to which reasons are given for the order or instruction contained in the message. The assumption might also be made that communication has not taken place with the printing of a notice; that communication will have taken place only after the employe understands the message and accepts the reasons behind it.

COMPULSION IS UNDESIRABLE

Wholehearted understanding and acceptance are more to be desired than compliance based on compulsion. This is even more true among supervisors than among workers because supervisory attitudes can be reflected within an entire work group.

If printed notices are not drafted so that they provide increased understanding, then they may be ignored or even resented as added "paper work" for the busy supervisor.

For example, should the administrator expect immediate and enthusiastic cooperation from all department heads in response to this notice?

(a) "It is requested that all department heads provide to the business manager within three days a list of all employes presently in their departments with their present pay-roll titles, names, length of service, rates of pay and other pertinent data."

Would fewer questions arise, less resentment be aroused, and quicker response be assured by this notice?

(b) "Department heads have agreed on the need for improved accounting and pay-roll procedures as recommended by our auditors. As part of the effort to improve our procedures the pay-roll department would like your help in checking the accuracy of its records.

"To make the job easier and to make it possible for you to reply within three days we have done the work of assembling and have attached for each employe in your department his present pay-roll title, his name, length of service, rate of pay and so forth. Will you kindly examine the attached material and make any corrections that are necessary? The auditors will return on Friday. Therefore, we should appreciate your effort to have all papers returned to the business office by Thursday night."

GIVE THEM A REASON

These illustrations help to point out the value of including the reason for a request. Another difficulty is that of drafting notices that are readable or clear in their meaning. The following paragraphs are intended to give first the unclear and second the more readable notice.

(a) "To all department heads—organization, job analysis, supervisory training and personnel administration will be discussed by Mr. Gordon of Cornell University at 12 noon on Thursday, October 22, in the interns' dining room."

(b) "Department heads are invited to a luncheon meeting in the interns' dining room at 12 noon on Thursday, October 22. The purpose of the meeting will be to discuss a research project in hospital administration to be sponsored by Cornell University in cooperation with the Central New York Regional Hospital Council and to invite the participation of our hospital. Mr. Gordon of Cornell will be present and will be glad to answer any questions that you may have either at the meeting or on an individual basis."

How can written communications be improved? In addition to verifying readability, in addition to giving reasons for any change requested, the greater use of written communications solely to set the stage for personal face-to-face discussion, or solely to confirm agreements arrived at in personal conversation might be more fully exploited. Numerous research studies and the experience of many successful executives lend support to the contention that there is no substitute for the face-to-face transaction, that written matter supplements but does not effectively substitute for personal dealing where personal conversation may be possible and practical.

These notes on communication are in a sense introductory, a small part of a broader survey. For real progress on improving three-way communications —up, down and across all levels and all departments of the hospital—intensive study is recommended.

WHAT ABOUT GRIEVANCES?

Before leaving the general area of communications, there is one item on which some supervisors expressed strong opinions. In each of the three hospitals, supervisors were asked, "What does or can an employe do when he feels that he has a gripe, complaint or grievance?" The complaint might be based on provable facts, on imagination, or might even be directed against the supervisor himself, but "is there a grievance procedure; do employes know about it; do they use it, and how does it work?"

In answer to these questions, it was learned that even some of the supervisors felt aggrieved because no adequate procedure was available for their employes. Those who expressed opinions opposed existing "open-door" policies as useless. They claimed that employes who went over the heads of their bosses, eventually to the administrator, either possessed superb courage or lack of imagination; that the "open-door" discourages action by employes, and, if used, serves only to undermine supervisors by encouraging by-passing and dealing with "higher ups" even on trivial matters. Quoting from Parkinson's report to the Hospital Council of Boston:[3]

"Adopting a problem (grievance) procedure requires one important discontinuance. Included in the 1942 edition of the American Hospital Association Bulletin 219 on 'Hospital

[3]Parkinson, Royal: Hospital Personnel Policy. Boston: Hospital Council of Boston, Inc., 1947.

Personnel Policies' is a recommendation of the 'open-door policy.' This means the director is accessible to the janitor, for instance.

"This is not a good personnel policy. On the contrary it is hazardous. In the first place, it doesn't work in practice. The janitor won't go to his office. Probably any director will agree that not 1 per cent of his employes use that approach. In the second place, if any employe uses it, he can only do so by going over the head of his supervisor, which is likely to break the morale of the supervisory group. In the third place, his fellow workers are likely to consider him as reporting on them to the director. Finally, the director can't get the facts necessary to fair settlement unless he gets the plaintiff's foreman in at the same time and learns both sides."

BETTER "CLOSE THE DOOR"

Therefore the "open door" has disadvantages from the point of view of the employe, who wants to continue his job in the same department; from the point of view of the supervisor, who is being undermined by appeal to higher authority prior to his knowledge of the grievance, and from the point of view of the administrator, who cannot be always accessible to hear every minor trouble and still get his own job done. There are ways to handle an "open-door" policy and to reduce some of the hazards suggested, but the hazards should nevertheless be recognized.

If a hospital has an "open-door" policy on grievances and plans to continue with such a policy it would seem appropriate to recommend a meeting of department heads and supervisory people including, if possible, some members from the employe group to discuss how the policy is working and possible methods of improvement. Effective operation of an "open-door" policy probably involves some training for supervisors so that they may recognize the need to handle in a diplomatic and careful way even those grievances which personally involve the supervisor. The supervisors should recognize the need to encourage employes to use the "open-door" policy. Those people who have supervisors under them and those who operate in "staff" jobs like the personnel director should recognize the need to treat employes who are aggrieved in a considerate way and yet in a way that does not undermine the immediate supervisor of the aggrieved employe. Arrangements of this type should probably be worked out among the groups involved in each hospital. There is no easy formula that can be described here that would be useful to all hospitals.

The alternative is a definite grievance procedure. Study might be directed to successful procedures worked out by companies and hospitals that have plans for employe representation, and by union and management groups. A real grievance procedure avoids leaping over heads, assures employes the use of established procedure without jeopardy, and provides a safety valve for pent up emotions based on real or imaginary complaints.

While the inauguration of a grievance procedure may result in increased work at the outset, the long-run possibilities are that employes might contribute to management's effort to improve personnel administration through the channel of upward communication.

PARKINSON CITES TURNOVER COST

When Royal Parkinson, labor relations counselor, prepared his report for the Hospital Council of Boston, he also observed:

". . . the average cost of replacing a resignee from the full-time staff of professional, office, skilled and less skilled workers may be conservatively estimated at $80. This includes advertising, recruiting, interviewing, training the newcomer, waste and loss during the learning process, and executive and clerical time from the start of the loss to the complete replacement. This estimate is probably too low.

"Thus, for every 100 persons whose loss would be avoided by specialized leadership, a hospital can afford to spend $8000 without increasing its costs. . . ."

The foregoing was offered as part of an argument for a full-time personnel specialist in any hospital with 150 or more employes. It might also serve as a persuasive factor in advocating supervisory development in personnel administration. It certainly points to the need for exact factual information on turnover.

Absenteeism and turnover are among the more serious handicaps that frustrate the supervisor's plan to get work done. Despite the reiteration of these two great problems by the majority of department heads, no adequate records were maintained in departments or any central office. It was not possible to diagnose trends or reasons for turnover and absenteeism among different groups within the hospital. Absenteeism was often attributed to the caliber of employe or to liberal sick leave accumulation practices, and turnover was usually accounted for, according to department heads, by "low wages."

Turnover seems to be heaviest in the nursing department and is largely explained by nursing directors on the basis of marriages, pregnancies, family responsibilities, husbands leaving town for other work, and low wages. None of these reasons includes elements within the control of the department as reasons for turnover. There has been no way to verify correlation between the reason given for leaving the job and any possible reasons that influenced the resignation but remained unstated.

Turnover also seems to run high among dietary and housekeeping workers, and among secretarial workers. The rate of turnover is lower on engineering jobs, where older people continue, perhaps because other employment opportunities are not available or because other opportunities offer less security of continuous employment. The laundry and dietary departments seem to be in more direct competition with outside institutions than other departments are. One supervisor referred to "a general exodus among dietary workers to obtain work with summer resorts and a great return to the hospital field when cooler weather sets in."

TURNOVER AMONG SUPERVISORS

Turnover also takes place among professional and supervisory staff. Perhaps 20 per cent of the department heads interviewed, and both of the assistant administrators, referred to the relatively short time in their present positions. Among technicians, some department heads stated that "where professional attainment constitutes a qualification for employment there is a westward migration across the country of people who have served their apprenticeship in eastern hospitals, because there is more money to be obtained in moving."

Among orderlies, dishwashers, cleaners, the entering jobs that require no special training, turnover seems to be highest, and the greatest number of personnel problems seem to arise.

Among the hospitals studied some statistics on turnover were available.

(*Continued on Page* 142)

Nurses Team Up for Better Care

Slide film shows how team nursing differs from functional and case nursing—and what it does for patients

ADVOCATES of team nursing say it is the greatest thing in nursing since the introduction of the lamp. Its detractors say it is cumbersome and expensive and, especially, that it is wasteful of personnel at a time when nursepower of all kinds is scarce.

Not so, reply the teamsters. The team method is wasteful only when it is improperly understood and used; skillfully applied, team nursing provides hospital patients with better, more personalized nursing care. Furthermore, it gives nurses a feeling of professional fulfillment—the kind of job satisfaction that is needed to keep hospital assignments from being nerve-wracking and frustrating in these times. This cuts down nurse turnover and, eventually, saves time and money, team enthusiasts claim.

Maybe, say the skeptics. But with so many transient workers in nursing, isn't it impossible to keep the team method going in the average hospital today? When a team member quits her job, the whole team is affected, and the hospital loses more than just one worker.

Still a matter of skill and patience, defenders insist. Values to patient and nurse are worth working and waiting for; when the team breaks down, build it up again. Eventually, good team nursing will stabilize the working force.

In a study conducted among nurses and hospital administrators in 1952 and 1953, research workers for Johnson & Johnson's nursing education program found team nursing the most talked about subject in the profession. Out of the J & J studies, eventually, came a talking slide-film, "Team Relationships in Nursing Care," that has been shown to nursing groups in hospitals all over the country during recent months. Developed with the cooperation of Eleanor Lambertson, author of the book, "Nursing Team Organization and Functioning," the slide-film shows how team nursing differs from case nursing and functional nursing, and what it does for patient and nurse.

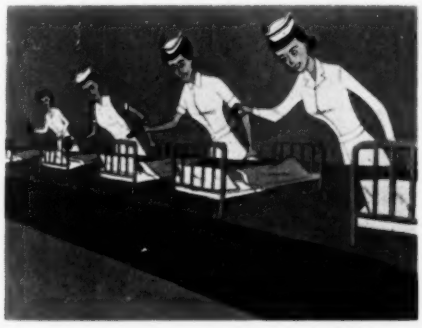
"The team concept is not altogether new, neither is it magic that will cure all nursing problems," said Wayne Comer, who directed the studies from which the film was developed. "It is designed to give direct graduate professional nurse planning, direction and supervision for all the nonprofessional personnel who are now rendering some phase of patient care in almost all hospitals today. The basic concept and hope of team nursing is that more and more graduate professional nurses will assume the rôle of planner, supervisor and teacher for nonprofessional personnel."

How these aims are accomplished is shown in detail in the slide-film, which tells the story of Mr. Smith, a hypothetical hospital patient. Condensed to about one-fourth its original length, the film is presented here with permission of Johnson & Johnson.

1. Mr. Smith, lying in his hospital bed, epitomizes all of the patients for whom the hospital exists and around whom the nursing team revolves. Helping him get well, physically and emotionally, is the purpose and climax of the efforts of all members of the team.

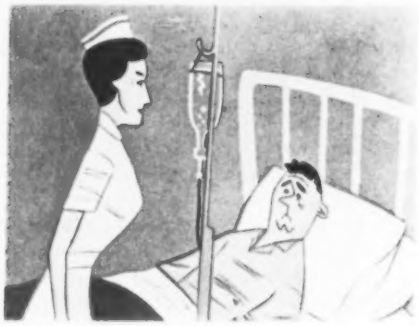
2. The nursing staff focuses on the patient. In team nursing, each element of the staff, *i.e.* graduate, student, practical nurse, and nurse's aide, is blended into a working unit whose functions combine and overlap to ensure greater effectiveness.

3. Functional nursing resembles an assembly line, with the patient being passed along from one person to the next on the basis of jobs to be done for him. In team nursing, each member of the group works *with* the patient according to his individual needs.



4. In functional nursing, jobs are grouped for economy of time and expediency of service, with one person assuming responsibility for a similar group of jobs. For example, the nurse's aide usually performs simple functions based on common knowledge plus preparation by on-the-job training. Here, a nurse's aide helps a convalescent patient out of bed.

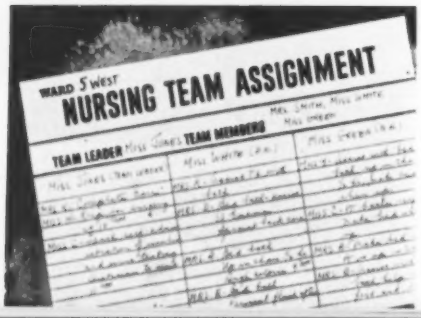
5. A student nurse helping a patient in traction. In the functional method, the student performs first at the assisting level and progresses in terms of her educational program. This method ignores the full potentialities of each member of the nursing staff both by forcing her to work alone and by limiting her duties to sharply circumscribed and defined areas.



6. The licensed practical nurse performs intermediate functions requiring skill and some judgment. Again, in the functional method, her duties are circumscribed and she, like other members of the group, loses intimate contact with the patient because she is primarily concerned with giving treatments and medications rather than with the needs of the patient.

7. The graduate nurse, shown here working with the patient in an oxygen tent, performs more complex functions that require a high degree of skill and judgment backed up by professional education. As leader of the nursing team, appointed by the head nurse, she is responsible for the assignment of duties and coordinates the functions of the entire group.

8. The nursing team goes into action, beginning with the conference which lasts for 10 or 15 minutes each day. The conference gives the members a chance to come together to talk over their experiences with the patients; to identify the patients' problems, and plan for their care. The team learns to work together through developing the plan.



9. A typical assignment incorporates pieces of both the functional and case methods. Once the assignments are made, once the plan of nursing is laid out by the team—coordination of activities is provided for through a clearly defined written plan demonstrating the relationship of team members who will participate in the care of the patient.

10. Away goes the nursing team, each member ready to carry out her part of the plan. The professional nurse may have total responsibility for the nursing care of selected patients or she may be assigned a functional area, such as administration of medications. The others in the group have their own assignments – but they always work as a team.

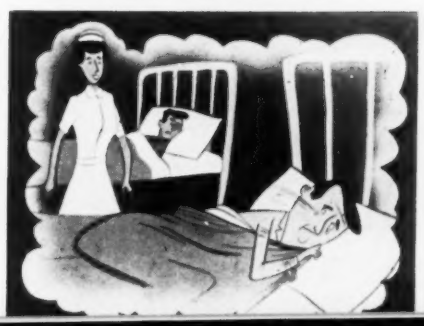
11. The contributions of each team member are invaluable in planning a patient's nursing care, for each member is an individual who sees things differently from any other member of the team. What she sees and hears she records or remembers to report and discuss at the daily conference, and the patient therefore benefits from the observations of all.

12. The patient progresses through various phases of his illness: very ill, with graduate nurse administering medication; sitting up in bed, being helped by practical nurse; sitting beside bed, being served tray by nurse's aide. As the patient progresses to self-direction of his own care, the need for supervision by the professional nurse diminishes.

13. The most important and, from the nursing point of view, most exciting member of the team is the patient, shown here as a most unhappy man. This patient, Mr. Smith, was admitted to the hospital for removal and biopsy of a tumor on his jaw. Something is preying on his mind and it is part of the team's job to help him face and overcome it.

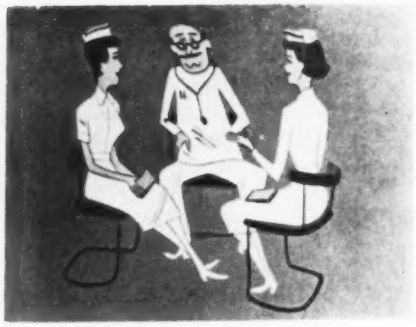
14. "No, thank you—I'm not hungry." The nurse's aide reports at the morning conference that when she went to pick up Mr. Smith's breakfast tray, he had eaten nothing and was just sitting staring into space. When she tried to discover what was wrong and convince him that the food would make him feel better, Mr. Smith only mumbled and turned away.

15. The practical nurse confirmed the aide's report. As she approached his bedside to make up his bed, he seemed tired and indifferent. "Mr. Smith seems to be putting up a wall between himself and the rest of us," the practical nurse explained. The situation seems to call for concerted action and the team developed its plans for his care accordingly.



16. The worried phantom of poor Mr. Smith hangs over the conference as the team constructs a mental picture of his problems and how it can best help him solve them. The practical nurse suggests that the team leader give Mr. Smith morning care so that she will have a chance to observe him.

17. In accordance with the team plan, the graduate nurse gave Mr. Smith his morning care. As she made his bed she talked with him casually, trying to find out what might be blocking his outlook. Gradually, the nurse elicited the fact that he was sure he suffered from cancer and was going to die.



18. So the main problem was identified and the team leader went into conference with the head nurse and the patient's doctor. She told the doctor of her own and the team's observations, thus giving him additional insight into Mr. Smith. The team then formulated plans to help Mr. Smith.

19. Time now for the doctor to talk things over with the patient who, for the first time, asked direct questions about the surgery involved. The possibility of the tumor's being either malignant or benign was discussed. Mr. Smith's fear of disfigurement and the loss of his job was relieved.

20. The nursing team goes about its various tasks, at all times keeping an unobtrusive eye on each patient in order to discover the problems of each. Because of teamwork, the group can watch all patients, guide them, and help each one solve his respective problems and get well quicker.

21. The nursing team has broken through the barrier of Mr. Smith's worries. Through team nursing care, each member of the nursing staff is utilized to her full potential, and because each one has contact with the patient, he has become a real person, not a problem in cold, clinical care.

22. When the team has done its work, Mr. Smith is able to return to his family and his job. Here he waves good-by to the group whose combined efforts helped to restore him to health by approaching him as an individual with problems and worries rather than as just another "case."

23. As a head nurse sees her team. From left to right: nurse's aide; practical nurse, student, and professional nurse. To the graduate nurse, team nursing affords an opportunity to become a leader and a teacher; to share her responsibilities, and to work at a higher and more satisfying level.

At the risk of being called (a) a radical and (b) a reactionary, a small hospital administrator urges:

Let's Get Out of the Restaurant Business!

PAUL A. SMITH
Administrator, Navarro County Memorial Hospital
Corsicana, Tex.

ALL administrators are, or at some time or other have been, plagued by the question of what to do about meals for personnel, relatives and visitors. This seems to be a common problem among small hospitals and it suddenly appears to me that we may have been using the wrong approach to arrive at a solution to a really important problem.

The hospital dining room was developed many years ago, probably for two excellent reasons. Nurses worked a minimum of 12 hours a day and were poorly paid for this work. To compensate for this low pay and to keep nurses from leaving the hospital long enough to eat out, nurses were given meals. In other words, a combination of generous and selfish motives resulted in an increase in nurses' pay. These combined motives are dangerous from a financial standpoint. Some hospitals still say "Take your meals and we will pay you a little less." This is true in our case. Other hospitals say "We will pay you more but you must pay for all the meals you eat." Neither system seems to be too satisfactory and the complaints about meals and salaries still continue.

JUST DON'T SERVE THEM

Now it seems to me (at the risk of being called both a radical and a reactionary) that there is a simple solution to this problem, at least for the small hospitals without training schools. Do away with the dining room completely and serve meals to *patients only*. Wait a minute; let me explain!

Most nurses work an eight hour day now, the day shift being from 7 a.m. to 3:30 p.m. with 30 minutes off for lunch. Why not set their hours from 7 a.m. to 4 p.m. with one hour off for lunch? Other businesses function through the noon hour with personnel taking lunch either from 11:30 to 12:30 or from 12:30 to 1:30. Work schedules could be arranged accordingly with little if any change. This would be true, not only on the nursing service but in all other departments of the hospital. Not only would it hold true for every department but it would hold true for every meal. Breakfast could and should be eaten by employes before they come to work or, if they are on the night shift, after going home. Nurses on the evening shift could be given an hour off for the evening meal, half of the staff taking off from 5 to 6 and the other half from 6 to 7 p.m.

Now come the questions: Even though we don't have a training school, we furnish living quarters for nursing personnel. What about their meals? If your nurses' home does not have a kitchen, put one in. Then let the nurses, *as adult members of society,* decide whether they will buy groceries and cook at home or eat out.

Next question: We are too far from town for nurses to go back and forth. What can we do? Answer: So are we and so are two or three small factories in this town. The factories do not furnish meals. If you have a canteen, sell sandwiches and coffee. Personnel can bring lunches. After all it is, or should be, only one meal a day.

What about relatives and visitors? Except in the most critical cases there is no reason whatsoever for hospitals to furnish cafeteria or lunchroom service to relatives and visitors. Hospitals should stay in the hospital business. If we sell meals to relatives and visitors we cannot make a fair profit without incurring the displeasure or even animosity of our customers. If we don't make a fair profit we must use patient revenue to feed relatives and visitors.

Times have changed. In many other ways hospitals have brought themselves up to a level with other businesses but we still continue to stay in the cafeteria or restaurant business when there is no justification for it. Few hospitals make money from their food service although changes in accounting procedures have helped somewhat to explain the loss. But why should we explain something for which there is no justification?

SHOULD GIVE TIME TO PATIENTS

Dietitians in small hospitals should devote all their time to seeing that patients receive proper, well prepared diets. As the situation now exists, however, dietitians operate a restaurant and must be responsible for all the duties and complaints which go with such an endeavor. As a result the patient is usually the last one considered.

Perhaps this discourse seems to advocate simplification to a ridiculous extent. We are not ready to undertake such a project yet. Sooner or later, however, it seems that hospitals must go out of the restaurant business. But tomorrow at noon 60 or 70 employes, including nurses, office personnel, x-ray and laboratory technicians, housekeeping personnel, orderlies, laundry workers, maintenance men, and last and least, the administrator will invade the dining room.

It is a touchy subject.

About People

Administrators


Dr. Basil C. MacLean

Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N.Y., since 1935, has been named commissioner of hospitals of New York City, succeeding **Dr. Marcus D. Kogel,** now dean of Albert Einstein College of Medicine of Yeshiva University, the Bronx, N.Y. After completion of his medical studies at McGill University in 1926, Dr. MacLean became assistant superintendent of Montreal General Hospital, Montreal, Que. In 1930, he went to New Orleans as superintendent of Touro Infirmary, and from there to Strong Memorial. During the years he has been director of the hospital he has also been professor of hospital administration at the University of Rochester. Dr. MacLean served in the army medical corps for two years during World War II.

Last fall at the annual meeting of the American Hospital Association he was presented the Award of Merit made annually by the association. He was the association's president in 1941-42 and is a charter member and former president of the American College of Hospital Administrators. Dr. MacLean is also a member of the New York State Hospital Association, the American Public Health Association, the Rochester Academy of Medicine, and the Monroe County Medical Association. He has long been a member of the editorial board of The MODERN HOSPITAL. He has been consultant to the Children's Bureau of the Department of Labor and to the Secretary of the Navy. He is a former chairman of the New York State Commission on Medical Care and is chairman of the hospital division of the advisory board of the American Red Cross.

Elise Biechler Gabriel, administrator of Mary Thompson Women's and Children's Hospital, Chicago, has left her position because of ill health. A former administrator of Westlake Hospital, Melrose Park, Ill., Mrs. Gabriel is a graduate of the hospital administration program at Northwestern University and served as a member of the faculty there for several years.


Dr. Karl S. Klicka

Dr. Karl S. Klicka, director of St. Barnabas Hospital, Minneapolis, since 1950, has been named director of Presbyterian Hospital, Chicago, succeeding **Leslie D. Reid.** Previously, Dr. Klicka had been director of Woman's Hospital, New York City, an assistant director at Grasslands Hospital, Valhalla, N.Y., and a medical officer in the army. He is a member of the American Hospital Association, the American College of Hospital Administrators, and the Hennepin County Medical Society. His M.D. was received from Western Reserve University, Cleveland, and his master's degree in hospital administration, from the University of Chicago.


William S. Brines

William S. Brines has succeeded **Dr. T. Stewart Hamilton** as director of Newton-Wellesley Hospital, Newton Lower Falls, Mass. For the past several years Mr. Brines has been administrator of Malden Hospital, Malden, Mass. Previously, he was director of Central Maine General Hospital, Lewiston, Me., and assistant administrator at Pittsfield General Hospital, Pittsfield, Mass. While there, Mr. Brines took a leave of absence to serve as chief of the hospital section of the War Production Board, Washington, D.C. Mr. Brines has also taught at Rutgers University.


Robert K. Lowry

Robert D. Lowry has been appointed executive director of New England Deaconess Hospital, Boston. He succeeds **Dr. Warren F. Cook,** director for the last 25 years. Formerly a captain in the medical administrative corps during the war, Mr. Lowry has been director of Deaconess for seven years. He is a member of the American Hospital Association and a nominee of the American College of Hospital Administrators. Dr. Cook has taken over the hospital's fund raising activities as executive consultant of the hospital. He is a former regent of the American College of Hospital Administrators, and has also served as president of the Massachusetts Hospital Association and the New England Hospital Assembly.


Elmer W. Paul

Elmer W. Paul, administrator of Flower Methodist Hospital, Toledo, Ohio, since 1949, is the new administrator of Methodist Hospital, Lubbock, Tex. In 1946, upon completion of the hospital administration course at Northwestern University he received the Malcolm T. MacEachern Medal and Award. Mr. Paul served his administrative residency at Wesley Memorial Hospital, Chicago. He is a member of the American College of Hospital Administrators.


Dr. Hiram Sibley

Hiram Sibley has been appointed director of the projected Yale-New Haven Medical Center at New Haven, Conn. Since June 1948 he has been serving as executive director of the Connecticut Hospital Association. A graduate of Harvard, Mr. Sibley was employed by the Security Trust Company of Rochester, N.Y., from 1931 to 1943. He left his position there as assistant trust officer to serve with the Office of Foreign Relief in the State Department in Washington, transferring in January 1944 to U.N.R.R.A. During two years in Greece, where he served as administrative officer, Mr. Sibley's duties included the rehabilitation of hospitals and the organization of malaria control programs.

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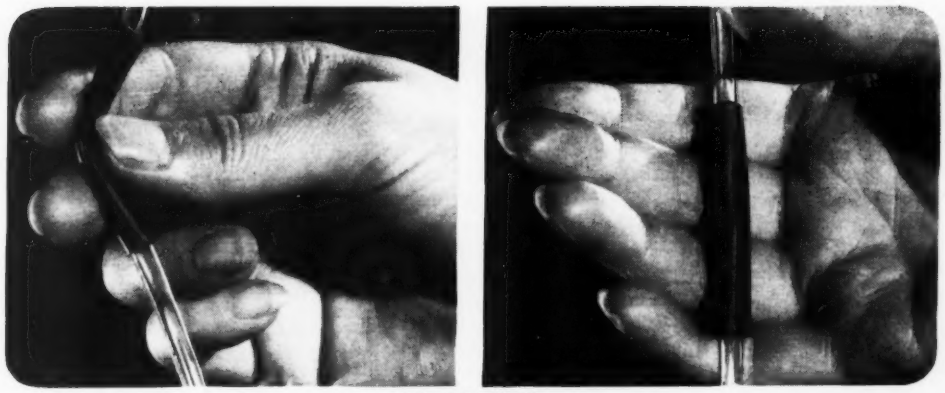

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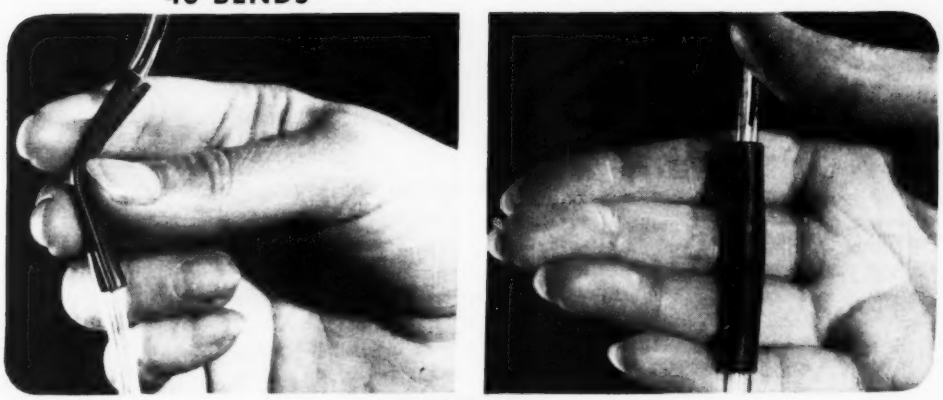

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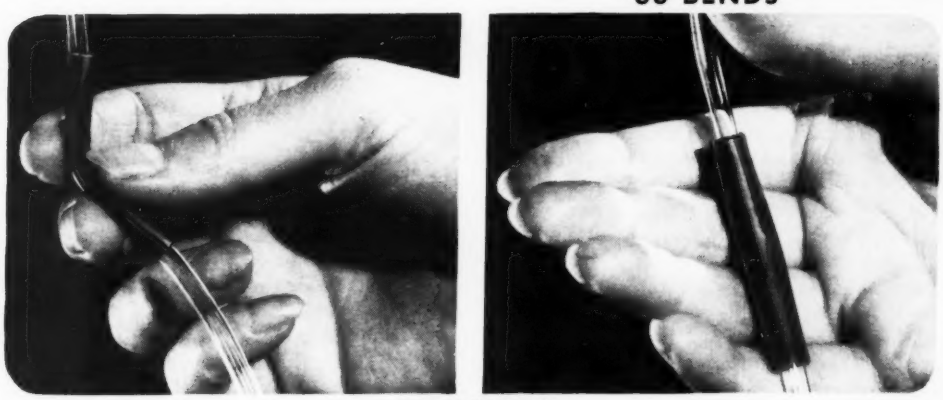

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True Measure of Medical Ethics

(*Continued From Page* 51)

the strays. Also, we realize that the A.M.A. itself sometimes provokes public resentment because, to the innocent bystander, certain of its utterances seem calculated to impress people that private physicians are interested primarily in their own advantage and not the public's.

We are resentful, moreover, when we hear the same doctors piously pontificating on what makes American medicine great. Witness the reaction of Fr. Gordon George, S. J., when he read that Dr. John W. Cline of San Francisco, former A.M.A. president, had described the doctor-patient relationship as a sacred thing—"something precious that has made American medicine the best in the world."

"Actually the progress of American medicine, like that of American industry," retorted Father George in the Catholic weekly, *America,* "stems primarily from the amazing growth of science and technical know-how. Add to this the efficient organization which provides corps of nurses, medical technicians and social workers, grouped around the fabulous technical resources of our modern hospitals and clinics, and you fill out the story. The 'precious something' in the doctor-patient relationship had precious little to do with all that. . . . For good or ill, the family doctor of our grandfather's day has succumbed to technological revolution."

From the Oath of Hippocrates, with its archaic form and everlasting good sense, on down to the present, however, physicians have shown more concern for proper conduct than most folks. The honorable ones always have placed emphasis on the self-sacrificing, altruistic aspects of healing, correctly appraising instinctive human resentment of anyone who exploits others' misfortunes. In the Middle Ages, to be sure, the rules of conduct became anything but selfless in intent. Wrote Fielding H. Garrison in his excellent *History of Medicine,* "In the Salernitan treatises of Archimathaeus, the physician is instructed to approach the bedside *humili vultu,* with the same humble mien and wall-eyed expression which we find in so many of the old miniature paintings. His remarks at table were to be punctuated by continued inquiries about the patient's condition, which he should always regard as grave, in order that either a favorable or a fatal termination might redound to his credit as wonder-working therapeutist or shrewd prognostician. He should not diminish his professional status by ogling the patient's wife, daughter, or maid-servant. Illusory treatment by harmless remedies was permissible, since otherwise the patient's mind might be ruffled by not getting his money's worth, while a normal recovery by the healing powers of nature might injure the physician's therapeutic reputation. A later authority suggests that, if a convalescent shows signs of ingratitude in the matter of payment, he might be temporarily sickened by some harmless dosing."

KING HENRY TOOK A HAND

Despite such callosities of honor, thinking man always has sought some higher meaning or aim in life, beyond the mere comfortable living of it, although, as an American College of Surgeons' publication has pointed out, also, "It is the history of human behavior that moral purpose frequently surrenders to economic pressure." One finds a familiar lesson on that score as early as the 16th Century. In 1512, King Henry VIII, no pillar of piety himself, granted a charter to the Barber-Surgeons Guild; they swore to be scrupulous in their moral and charitable relations with their patients in return for an exclusive right to practice surgery. By 1543, Henry had passed two acts denouncing the greed of surgeons "minding their own lucres" and neglecting the poor; as a countermeasure, he licensed lay practitioners professing a knowledge of herb or folk medicine, thus affording a loophole for the unqualified. Here we find an early example of "lay intervention" when doctors neglected their duties to humanity.

In 1803, a literary milestone in professional conduct was achieved by Sir Thomas Percival, honorable English gentleman and physician. In approximately 160 fulsome, aphoristic paragraphs, Percival spelled out "Medical Ethics: or, a code of Institutes and Precepts adapted to the Professional Conduct of Physicians and Surgeons; I. In Hospital Practice. II. In private, or general Practice. III. In relation to Apothecaries. IV. In Cases which may require a knowledge of Law. To which is added *An Appendix;* containing A Discourse on Hospital Duties; also Notes and Illustrations."

Percival's Medical Ethics has been widely used as a model statement of what a doctor should be. When the A.M.A. was founded in 1847, his work furnished a pattern for its code. It is natural, of course, for a group of people organized for service to state and restate their objectives from time to time. The fact that the A.M.A. rewrote its code in 1903, 1912, 1940 and 1949, and in 1952 ordered a restudy of it, *does* allow room for speculation, however, on whether the profession has been happy with its ethics.

The four official revisions of the A.M.A. code, as a matter of fact, do not represent all the ethical pulling and hauling that has gone on. In 1882, the New York State Medical Society, having failed to persuade the A.M.A. to change its code, wrote a simple, brief code of its own, permitting its members to consult with homeopaths, whom the A.M.A. then regarded as cultists, whereupon the A.M.A. stoutly refused to seat the New York State Medical Society in the House of Delegates. The A.M.A. recognized a new group in New York State, and the rebel society stayed out until 1903, when the new A.M.A. code dropped the bar against consultation with homeopaths and the wayward returned to the fold.

One characteristic of moral truths, most would agree, is that they are unchanging. Individual man reached moral maturity thousands of years ago. The bare essentials of amity have not changed since. Yet the A.M.A. has altered its code four times and is now in the midst of overhauling it again. For example, last December the House of Delegates adopted the Council on Constitution and By-Laws' recommendation to rewrite Chapter I, Section 5, now entitled, "The Relationship of the Physician to Media of Public Information." (See J.A.M.A. Dec. 26, 1953, *p.* 1549.)

While the revision gives the American College of Surgeons no relief in its independent efforts to tell the public the truth about the ethical deficiencies of some doctors, it is nevertheless a clear and constructive treatment of a sore point. It recognizes that the physician is often caught in the middle in informing the public of medical advances: "Refusal to release this material may be considered a refusal to perform a public service, yet com-

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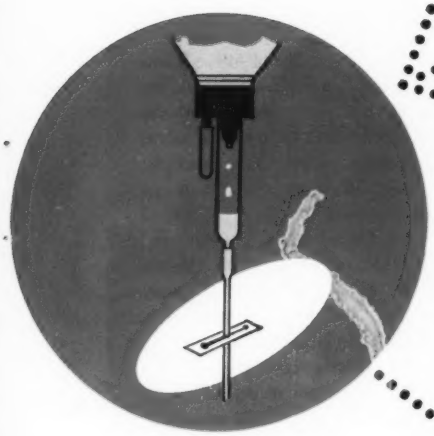

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pliance may bring the charge of self-seeking or solicitation." It tells him he can talk to the press about reports discussed in open medical meetings or published in medical journals but advises him to "seek the guidance" of his county and state medical societies. Important to hospital administrators, the new section endorses articles about hospitals, clinics or laboratories "inspiring public confidence in the procedure described," provided they are authoritative and have the appropriate institutional blessing. In brief, almost anything goes as long as the publicity is favorable to medicine.

The Council on Constitution and By-Laws, under the judicious chairmanship of Dr. Louis A. Buie of Rochester, Minn., is contemplating other changes in the code but "has adopted the policy of proceeding slowly."

What is the reason for proceeding at all?

NO CHANGE IN MORAL INTENT

If you study the history of the A.M.A.'s code of ethics, you must concede that there has been no change in moral intent or over-all idealism; indeed, in the first revision of the code, the A.M.A. in 1903 made it more difficult to live up to its ethics by inserting a paragraph concluding in effect that it is wrong to deceive or cheat a patient—*i.e.* doctors should not split fees resulting from the referral of a patient from one to another.

This brave attempt to curb fee-splitting has lived on to haunt organized medicine. In 1952, the Iowa State Medical Society wrote an elaboration of the A.M.A.'s *Principles of Medical Ethics* making it ethical for an independent referring physician and an independent surgeon to submit to the patient a combined, unitemized bill with the understanding that it covers the fees of both. This is unethical, according to the A.M.A. Judicial Council. In 1953, Iowa elaborated its elaboration, making it all right for the referring physician and a surgeon to send the patient a combined bill if it is itemized to show how much each is to receive. The A.M.A. again said it was sticking to its own interpretation of its code. Its own interpretation is that it is unethical for doctors to resort to subterfuges; they should send separate bills when, as independent practitioners, they work together on a case.

At this writing, the A.M.A. stands by its code, its Iowa constituent stands by *its* code and, there is reason to suspect, some members of the A.M.A. stand by neither. They just want to split fees as they always have. No student of the situation can feel anything but sympathy for the A.M.A. in the embarrassment some of its members cause it.

In 1953, New York, West Virginia, Illinois, Iowa and North Carolina all asked that the ethics be revised to permit the combined bill form of fee-splitting. The same demand was made by the American Academy of General Practice, in the interest of its 18,000 general practitioner members. On the other hand, the American College of Surgeons, representing 19,000 surgical specialists, has upheld the A.M.A.'s ban on fee-splitting in any form.

With great wisdom and infinite patience, Dr. Buie and his Council in June 1953 elected not to make a report. In December, he reported that the Council would conduct a questionnaire survey of state medical societies to determine their policies on billing procedures. This coming June, he will report its findings to the House of Delegates.

It is interesting to speculate on what Dr. Buie can recommend. It is hardly likely that he will find philosophical fault with the opening of the *Principles of Medical Ethics:* "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration." When medicine ceases to hold this view in substantial numbers it will cease to be a profession and become a trade, for it will have ceased to place service above profit. There are cynics who say that doctors already have sunk into this commercial rut; the cynics derive much ammunition from those who would make fee-splitting ethical, but we know too many honorable physicians to believe medicine is yet dead as a profession.

What possibly can Dr. Buie recommend except that medical men should live up to their ideals rather than down to their acquisitive instincts? It is not likely, of course, that he will go so far as to say that doctors who place selfish interests above their patients are behaving like moral imbeciles and it is from them that the real misunderstanding of ethics comes. But he can, and probably will, take the position that medicine's moral principles are unchanging in their truth. Why then do doctors, who as a class exemplify the good life probably better than any other group, have so much trouble phrasing their ethics?

Once you think about it, the answer is quite simple. We know of no moral code on earth that cannot be reduced to a one-page statement. Yet Percival's Medical Ethics required 160 paragraphs and the A.M.A.'s, though a good deal less prolix, consumes 50. It simply does not take that many words to state the various ways in which a man should love his neighbor as himself. There must be something else going on here.

Skipping through the 1949 edition of the *Principles of Medical Ethics,* we immediately discover that an ethical physician's definition of what is moral has been rather picky. For example, "The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offense against recognized ideals are unethical." Did this mean it was immoral in some communities to give out business cards and immoral in other communities not to do so? What has all this to do with ideals or morality, anyway? Happily, this confusing bit has now been deleted.

Later in the code, we find that it is a matter of ethics that a physician "should affiliate with medical societies and contribute of his time." It is a good idea for a doctor to be a joiner, certainly, but can we maintain in this land of the free and home of the brave that it is immoral to go one's own way and not "belong"?

A MATTER OF MANNERS

Going on, we find it is unethical if a physician making a social call on another physician's patient talks about the patient's illness. Throughout the code of ethics, from Percival on down, we seem to detect an almost paranoid sensitivity about what the other fellow is up to—no good, apparently. When several physicians are summoned, the first to arrive is in charge but must withdraw when the regular family doctor shows up. These, we see, are not moral principles but details of good manners—etiquette. The difference is approximately as follows: It is bad manners to eat peas with your steak knife, but not immoral. It would be immoral to stab your hostess with the knife, but not bad manners necessarily, unless you did it at the table. About two-thirds of the A.M.A.

(*Continued on Page* 102)

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Principles involve niceties of conduct. Apparently, doctors in the good old days gave each other a lot of trouble stealing patients, or no one would have thought to elevate the order of their comings and goings to a moral level.

If this be true, we now can see to what extent medical ethics have misled us. Can it be that they are not used primarily for the protection of the public, but for the protection of doctors, one against the other? Obviously, there was nothing unethical or immoral in a general practitioner's giving a newspaper a statement on what religion means to him. Rather, he was behaving in a manner reflecting glory on a noble profession. The man who censored him, in contrast, was clearly ignoble. He was catering to professional jealousy. Envy is a deadly sin, even if the doctors' code does not hold it to be unethical.

Nonetheless, the G. P. would be adjudged unethical by definition of Chapter I, Section 4, entitled, "Advertising." This says it is unethical for a physician to solicit patients. The innocent reader turning to the 1953 Section 5, "The Relationship of the Physician to Media of Public Information," is bound to wind up in confusion, however. Didn't he read, under Advertising, that "Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned? Self-laudations defy the traditions and lower the moral standard of the medical profession. . . ."

WHAT DOES IT MEAN?

What goes on here? One section plainly says it is unethical to talk to reporters and writers for publication and the next section says, just as plainly, that it is quite all right if the physician is in the clear with the proper medical authorities and officials and has the patient's permission. Pondering all this, we are forced to the conclusion that the medical profession has no clear idea of what constitutes advertising, which is the purchase of display space or performance time for the purpose of attracting attention and selling goods, services or ideas. The section, Advertising, contains a mixture of injunctions against advertising, capping and steering, false pride, bragging and publicity-seeking. It says nothing about the all-important question of motivation.

A reading of the 1847 code of ethics shows that advertising was identified with quacks who boasted of radical cures and lied about their secret remedies. Anyone who solicited patients was a quack. Today, there is still a big problem of accuracy and reliability in medical publicity, but it would not only insult our intelligence but constitute libel to say that the thousands of doctors whose names appear in newspapers and magazines every year are quacks. Whatever the intent in 1847, the free dissemination of medical information has come a long way since then. It is impossible to turn back the hands of time, as the A.M.A. recognized in 1949 when it first introduced Section 5 in its code, albeit somewhat clumsily.

There are a number of such contradictions in the existing code, or at least in the interpretations of it. Those who do not like the frankness of Drs. Paul R. Hawley, Evarts A. Graham, Loyal Davis, Alton Ochsner, Fred W. Rankin and other A.C.S. officials repeatedly say that it is downright unethical for one part of the medical profession to criticize another part in public. But the code merely says that criticism should be avoided when one doctor succeeds another in charge of a patient. The men who speak out against medical evils like to quote the code on the fact that "A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession." Those who prefer to oil the troubled waters quote the *next* sentence, "Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions. . . ."

In actual experience, other factors are much more important than the code of ethics in determining whether the personal publicity coming to a doctor is anything other than "unfortunate," as it is frequently termed. Is the doctor in private practice, as distinguished from teaching, research or administration? Does he receive a salary rather than work for fees? Is he old or young, not well established, or a man of distinction and "weight"? Does he say things which glorify his profession, or is he critical of its policies or practices?

In this advertising age, when some people in public relations behave as if getting publicity was itself a virtue, any interpretation of ethics to preserve the so-called "conspiracy of silence" in the medical profession is bound to be laughed out of court. Today, as far as we know, doctors are the only important class of people who make any pretense of opposing public expression of interest in one of their number. Any attempt to control the public utterances of the medical brethren which does not make a proper distinction between advertising and information of public interest merely preserves the obsolescent character of the medical profession as a secret fraternal order in which, without mutual protection, all feel vulnerable. Worst of all, medical censorship inevitably runs the risk of abridging the constitutional guarantee of free speech and free press to all citizens, including M.D.'s.

LEAKE FIRST TO SEE FALLACY

Apparently the earliest person to recognize the fallacy that the *Principles of Medical Ethics* confuses etiquette with ethics was Chauncey D. Leake, now dean of the University of Texas Medical School at Galveston. In 1927, Dr. Leake (Ph.D., not M.D.) published a book, *Percival's Medical Ethics*. Every ethical physician should read it. Says Dr. Leake: "For the average physician, medical ethics (of which there is no satisfactory exposition) means only medical etiquette, and actually there is usually as great a penalty attached to a transgression of one as to the other. . . . *Medical ethics should be concerned with the ultimate consequences of the conduct of physicians toward their individual patients and toward society as a whole, and it should include a consideration of the will and motive behind this conduct.* The difficulty is that professional courtesy is put upon the same plane and given the same respect as professional morality. . . .

"The fundamental problem supposedly met by formulating standards of medical etiquette is the financial success of the individual physician, and, incidentally, the prestige of the profession. Morally this ought to be jeopardized when the common dictates of decency are violated, so far as conduct toward society is concerned. Actually, unless such a violation is grossly vicious and apparent to anyone (*i.e.* officers of the law), medical etiquette requires that those in a position best qualified to expose the wrong must preserve silence, in order that one practitioner may not thus obtain a commercial advantage over another, and that accusations and countercharges

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may not bring the profession into disrepute. . . ."

The upward-spiraling path of private medical practice in America is littered with medical martyrs to the fallacy which Leake lays open with one clean stroke. We have only to hark back a year to find an example of an attempt to discipline a doctor for behavior which was ethical but a breach of etiquette. The Chicago Medical Society charged Dr. Loyal Davis with unethical conduct for telling reporters that he thought fee-splitting was increasing in Chicago. The Medical Society did not address itself to the question of whether fee-splitting was right or wrong, existed or was increasing, but only whether Dr. Davis was unethical in saying what he did. Its Council finally dropped the charges, after at one time voting him guilty.

At this point, it should be evident that American medicine needs a new code of ethics. Rather, it should be said that it needs, for the first time, a genuine moral code and, secondarily, a set of rules for professional conduct. The ethics and etiquette in the present *Principles of Medical Ethics* should be disentangled and put in their proper relationship to one another. The need for this seems to have been in some measure felt by Dr. Russel V. Lee of Palo Alto, Calif. At the A.M.A.'s December meeting he introduced a resolution proposing to substitute a new introduction for the code. Dr. Lee offers 10 broad obligations (J.A.M.A., Dec. 26, 1953, *p.* 1548). They probably could be more forcefully stated, for they contain a number of hedges, as for example, the first obligation in practicing the art and science of medicine, he states, is "To make these benefits accessible to all who need them insofar as facilities permit." Moral principles should contain no "insofar's" or other "outs." It is understood that no human being will do more than humanly possible.

The Lee resolution was laid aside for future consideration while the Buie Council takes up more urgent questions, such as what to do about fee-splitting. But the fact remains that Dr. Buie has a golden opportunity to do more for the moral understanding of medicine than anyone since Hippocrates. He can, to be specific, correct Sir Thomas Percival's misuse of the term, medical ethics, and help the medical profession to distinguish between what is of major and what is of minor consequence in the achievement of its ideals. The new thinking should seek to keep ulterior motives and honorable intentions straight in contemplation of disciplinary action, the same as the law distinguishes between punishment of a felony and a misdemeanor.

We shall be happy to let the A.M.A. write its own detailed rules and definitions of professional conduct. As further stimulus to ethical reform, however, we offer our own rough draft of a moral code for doctors (page 51), tossing it on the table for discussion, constructive or destructive, anticipating that it will be shredded and disintegrated. All we hope is that, since the assignment exists and Dr. Buie has it, the medical profession will display the character, integrity and energy to tear away the last shred of the dry-rotted veil of fraternal mystery in which it has traditionally enshrouded its conduct. We are confident that the sum of its respect for life, its devotion to facts, its inherent honesty and its great knowledge can form a sunlit rock on which any real doctor can stand, unashamed. The public has misgivings only as the medical profession manufactures them.

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Survey of hospitals reveals

Prevailing Practices on Drug Inventories

DANIEL L. DROSNESS

Lasker Foundation Fellow in Medical Administration
Health Insurance Plan of Greater New York

THE professional value of a drug formulary has been established in the hospital field.[1,2,3] An economic standard for hospital pharmaceutical inventory turnover (*i.e.* four times per year) continues to be advanced[4] but recent hospital literature has not re-evaluated this standard in the light of the current increase and diversification of production in the pharmaceutical industry.

Another guidepost has been put forth for inventory control in the form of inventory per active bed.[5] However a standard dollar value for such a formula is not advanced. Marquand[6] suggested that an average current (1947) figure based on total inventory should be $120-$125 per active bed. He speculates that ". . . if it were desired to show a figure for the pharmacy, one would have only to take the proper proportion of the total."

Archambault[7] states that ". . . current statistics (1952) indicate that 15 to 30 per cent of every supply dollar at a hospital goes into the drug purchases." Applying these percentages roughly to Marquand's figures, one gets an average suggested pharmacy inventory of $18-$38 per active bed (number of active beds = average daily census). In a 1951 round table discussion,[8] the figure advanced was $25 to $30 per hospital bed, but one person ventured the opinion that the average value of inventory is probably double or more what it would have been four or five years ago. It is interesting to note that the concept of inventory per active bed is absent in this discussion and therefore precludes comparison in anything but rough form with the estimate of Marquand.

PHARMACY SURVEY

In order to gain a clearer picture of current purchasing and inventory experience, a nationwide survey (of 509 institutions) was conducted among large, general, nonprofit, nongovernmental hospitals. Special reference was to be accorded the rôle of the drug formulary insofar as it related to the turnover of inventory. The size of the survey sample chosen for inclusion in this study was of necessity a large one. A previous nationwide survey[9] directed to every hospital pharmacist in the United States resulted in an 11 per cent response. These replies yielded much information, but unfortunately certain areas of inquiry produced such grossly atypical reports of the cost of drugs that the authors asserted that ". . . (this) probably is attributable to estimate or guesswork by the pharmacists in these hospitals who may not have available accurate records of total purchases."[10] Accordingly, in order to eliminate this failing to as great an extent as possible, it was decided that the questionnaires in the present survey would be addressed to hospital administrators. Thus, if interest was aroused, it would be more likely that correct information would result. To a certain extent, it would also reflect the interest in pharmacy affairs on the part of administrators.

Any appraisal of the inventory turnover rate must assume that the dollar cost of pharmacy purchases be reflected accurately in calculation of the volume of sales. Owing to varying degrees of departmentalization in hospitals of different size and also to variation in accounting practice, it was necessary to assure the fact that a purchase credited to the pharmacy would be entered on the pharmacy inventory. If such purchases were allocated directly to other departments without passing through pharmacy stores, the dollar volume of such items had to be accounted for, lest they invalidate the inventory turnover ratio. The latter was calculated in a standardized way, *i.e.*

$$\frac{\text{Annual Cost of Sales (1952)}}{\text{Annual Inventory (1952)}}$$

where cost of sales equals purchases plus or minus change in annual inventory for past year (1951-52).

Every effort was made in designing the questionnaire to enable standardization of any possible contingency arising from such variation. In this manner the investigator would be supplied the raw figures and he would make the necessary mathematical translations into rates.

COLLECTION OF DATA

Survey questionnaires were returned by 191 institutions, representing 37.6 per cent of those polled. The distribution of these returns, by size of hospital, is shown in Table 1 on page 108.

Twelve of the hospitals responding did not furnish adequate information to allow calculation of the inventory per active bed. Of the remaining 179

This study was prepared while Mr. Drosness was administrative resident at the Reading Hospital, Reading, Pa.

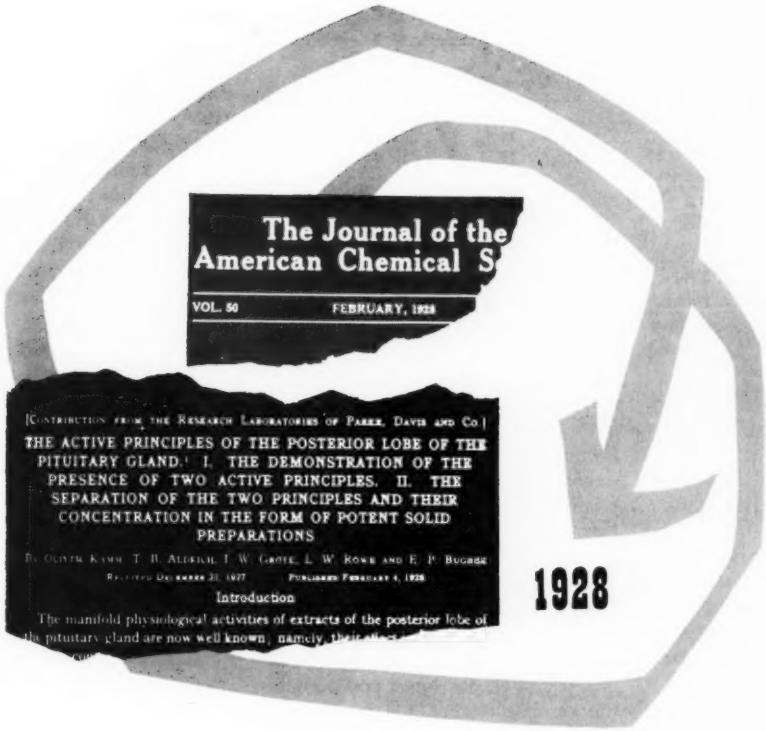

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Table 1—Pharmaceutical Survey Response by Hospital Bed Capacity

Bed Capacity	Hospitals Surveyed	Responded	Percentage
200—299	303	104	34.3
300—499	173	71	41.0
500—and over	33	16	48.5
Total	509	191	37.6

institutions, 70 operated with a drug formulary and 109 without a formulary. Both groups contained some hospitals where the process of taking inventory was by estimate rather than actual physical count. Statistics from these institutions were deleted in order to assure greater authenticity of reporting. Finally, those hospitals which did not provide complete information, permitting accurate calculation of the annual inventory turnover ratio, were removed from the study. As a result of this process of elimination there remained 40 hospitals operating with a formulary and 62 hospitals without a formulary.

No element of adverse selection appeared as a result of these procedures. The relatively small percentage of hospitals utilizing an estimated inventory was divided almost evenly on a percentage basis between those hospitals having and not having drug formularies.

Following are the findings calculated from the data furnished by the respondent hospitals:

1. *Pharmacy Inventory per Active Bed.* This calculation was made uniformly for all 102 institutions. The mean inventory per active bed in hospitals using a drug formulary is $75. In those hospitals where no drug formulary is used, the mean inventory per active bed is $98.

2. *Pharmacy Inventory Turnover Rate.* This calculation was made uniformly for all 102 institutions. The mean inventory turnover rate in hospitals using a drug formulary is 5.2 times per year. In those hospitals where no drug formulary is used, the mean inventory turnover rate is 4.1 times per year.

(Note: These differences are statistically significant and would be expected to occur very rarely purely as a matter of chance.)

INTERPRETATION OF DATA

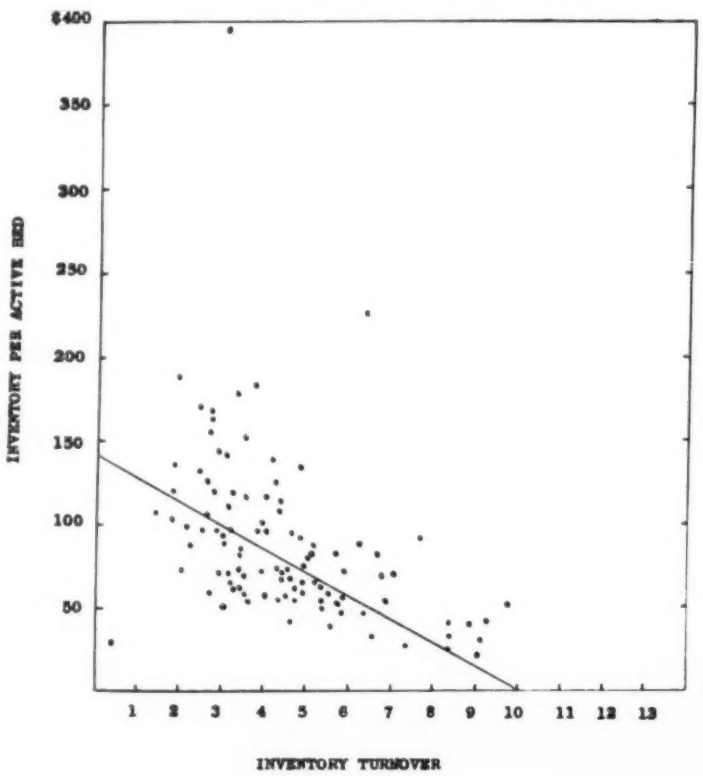
1. *Analysis of Interest Factor.* The additional control of drug inventory that management gains through the utilization of a formulary is significant. However, if an inventory turnover rate of four times per year continues to be advanced as a standard of operating efficiency, it would appear from the results of this study that the adoption of a formulary is not a critical factor. Yet, it must be realized that although the survey returns represented a good random sample by size, of hospitals of similar type, certain other factors remain to be assessed. It has been definitely shown that persons who respond to questionnaires have different characteristics, and possibly different environments, from those who do not respond. Probably the lack of a well developed cost accounting system lessened the incentive to complete questionnaires. It must be remembered that the sole reason for discarding 89 replies in the final analysis was lack of specific information required in order to calculate inventory turnover and inventory per active bed.

One might reasonably conjecture that the sum of the attributes comprising administrative interest and the ability to provide detailed departmental operating statistics should result, on the average, in a more efficient departmental operation. This being the case, the observed difference between the mean values encountered takes on added significance.

Forty per cent of the replies came from hospitals using a formulary. Previous studies[11,12] reveal that the percentage of institutions with formularies replying to pharmacy surveys were 20 and 26 per cent respectively. Therefore, the high index of interest among this group appears to substantiate the proposition that the nonrespondent institutions without formularies may operate less efficient pharmacies and hence show turnover ratios below the 4.1 average of the nonformulary hospitals that replied.

(*Continued on Page* 110)

Fig. 1—Line of Average Relationship Between Inventory Turnover and Inventory per Active Bed, Selected Hospitals, 1952



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2. *Trends Affecting Inventory Standards.* (a) Antibiotics — The current widespread usage of broad spectrum antibiotics has had an effect upon total inventory turnover. Many drug firms have entered actively into this phase of pharmaceutical manufacture and the marketing competition has become intense. This has resulted in the tendency to purchase cautiously in view of the expanding supply and possible further decline in the price structure. With the decrease in unit price, the volume of prescribing has continued to increase. Under these conditions the turnover ratio of this segment of pharmacy inventory tends to raise that of the inventory as a whole.

(b) Pharmacy Manufacture — In recent years a trend has developed toward increasing the manufacturing potential of the hospital pharmacy. Under such conditions, large inventories of certain items can be eliminated because the facilities for manufacture are available on the premises.

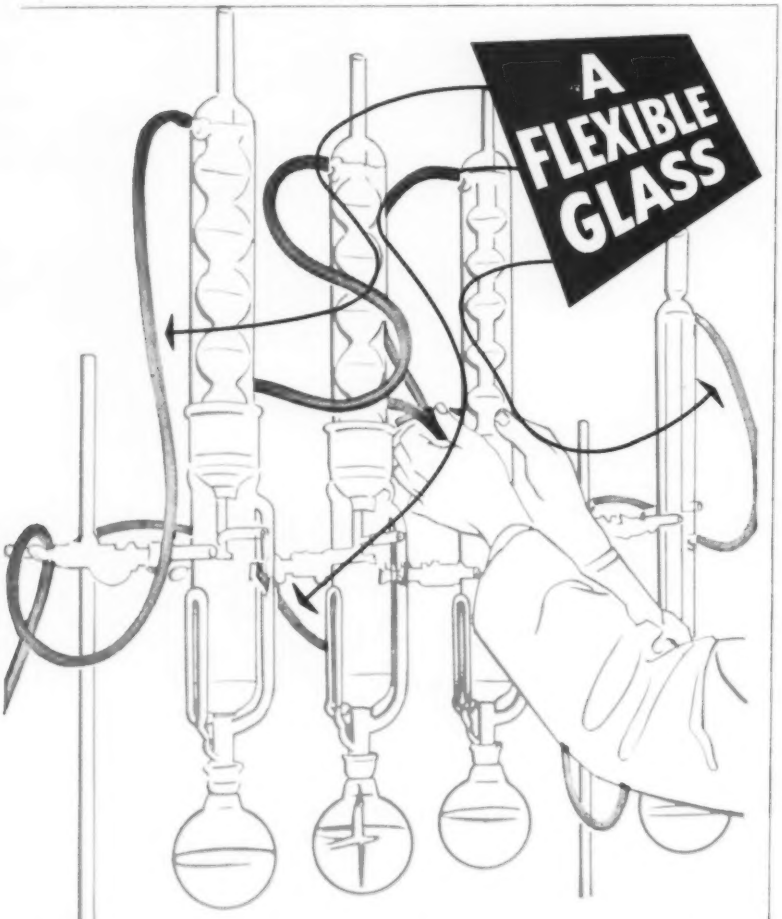
(c) Economic Factors — The recent general inflationary trend has undoubtedly caused an increase in the dollar value of the average pharmaceutical inventory per active bed. Any empirical attempt to correlate the rate of inventory turnover with inventory per active bed is best made at a point in time. Should correlation exist, the relationship between the two characteristics may be described graphically by a "regression line" indicating that inventory per active bed diminishes as inventory turnover increases.

3. *Correlation of Inventory and Turnover.* In Figure 1, the straight line represents an assumed correlation between the two variables. Actual figures calculated from data furnished by the 102 hospitals are shown by the black dots. The fitting of these data to a straight line may be called into question on two grounds, one mathematical and the other economic. If the straight line used in the analysis of this relationship is examined critically, it will be noted that several points deviate markedly from the line. Reexamination of the data reveals that two hospitals represented by the points at greatest distance from the line of average relationship are really special cases. It may properly be questioned whether they should have been included in the study at the start. For example, one hospital having a turnover rate of 3 and an inventory of $396 per active bed supplied the information that the 1952 inventory was taken by an outside firm at list price rather than at hospital cost. In 1951, the same hospital calculated its own inventory at actual hospital cost. Thus my calculations were affected materially by this discrepancy.

Information from the other institution revealed that its pharmacy encompassed a much wider range of function than is usually observed. The department handles all surgical instruments, surgical and laboratory supplies. It is therefore only logical that such a hospital would carry an inventory as high as $232 per active bed. Further justification for this lies in the fact that the turnover rate is 6.3 times per year.

Nevertheless it is evident that the straight line is not an entirely satisfactory fit mathematically for all the observed values. A hospital pharmacy must stock a wide range of items to meet the needs of the patients in a general hospital. It is folly to allow the inventory to drop to a point where adequate care of the patient would be jeopardized.

However, the regression line illustrated in Figure 1 is not without util-



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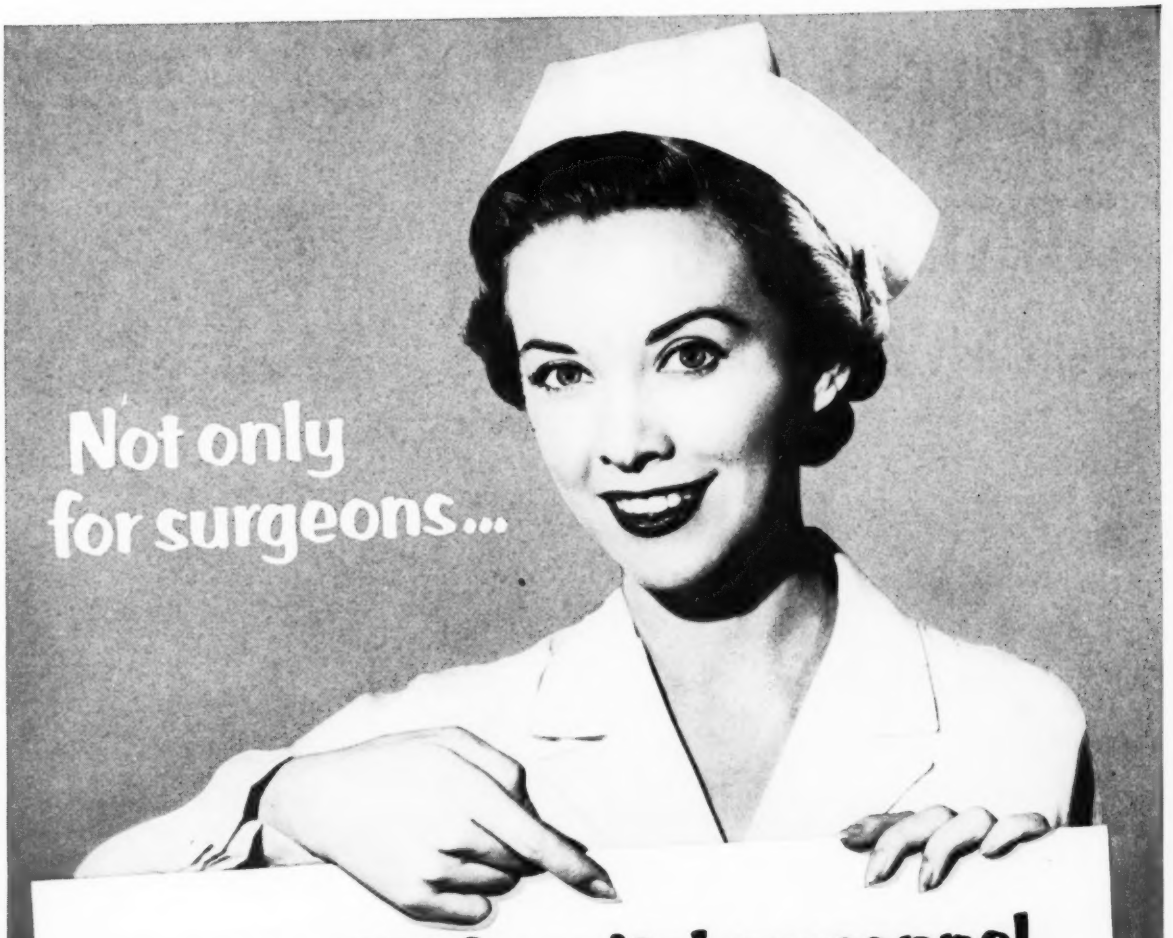

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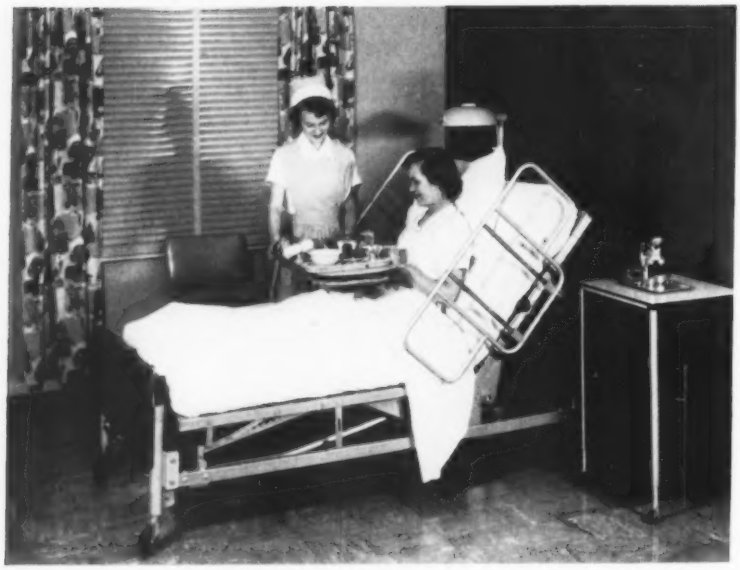

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ity. Inventory turnover rates in the range from 3 to 6 times per year show almost a linear relationship with the inventory per active bed. Since the critical area of discussion with regard to standards for inventory turnover rates center on this same area, a reasonable degree of predictability is still possible from the regression coefficient. On the average, an increase of one unit in the inventory turnover rate will be accompanied by a decrease in the inventory per active bed of $13.60.

CONCLUSIONS

1. *Inventory Turnover and the Drug Formulary.* Hospitals utilizing formularies show a 27 per cent greater inventory turnover rate than do hospitals not having formularies. This is interpreted as a decided economic advantage.

2. *Standard for Inventory Turnover Rate.* The old standard of four times per year is outdated. I advocate a turnover of at least five times per year for the large general hospital as being more in accord with modern hospital pharmacy operation and the pattern of medical prescribing.

3. *Standard for Inventory per Active Bed.* A current standard for pharmacy inventory of $75-$85 per active bed is advanced as a reasonable average figure under current market conditions. This is based on a correlation with a turnover rate equal to five times per year.

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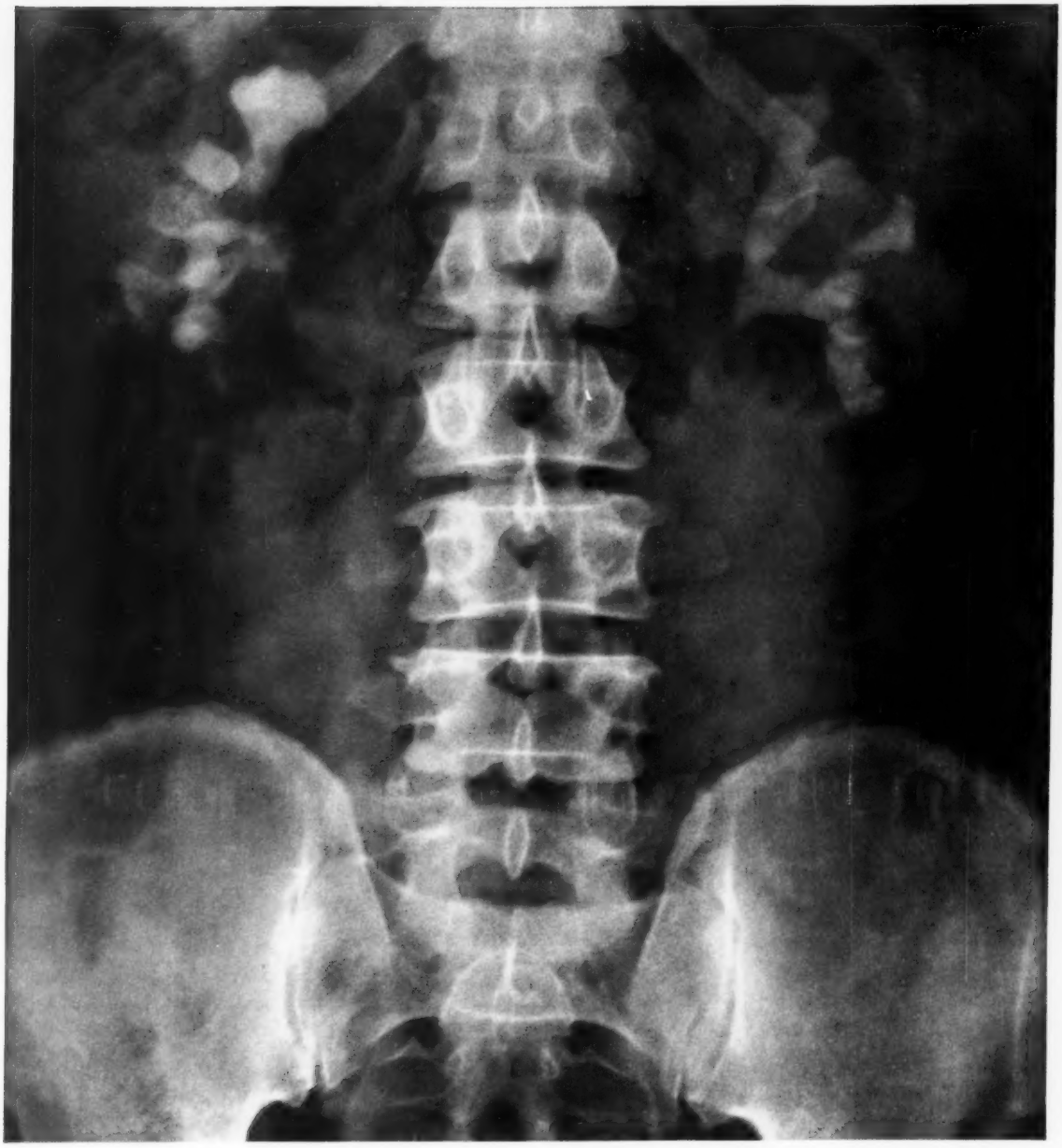

First radiograph: Note calculi, two kidneys.

Now . . . and later

On this page and the next are reproductions of radiographs and color photographs that "highlight" a classic nephrotomy. Here is an example of how radiography and photography, used in combination, are aiding today's diagnosis—tomorrow's reference and research.

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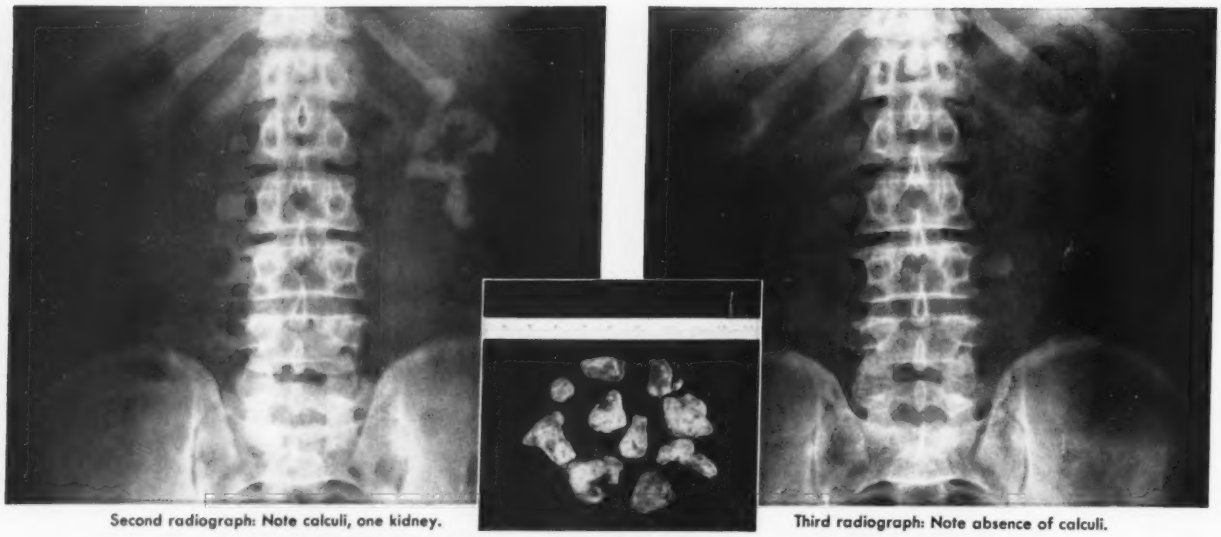

Second radiograph: Note calculi, one kidney.

Third radiograph: Note absence of calculi.

NEPHROTOMY—with removal of calculi from right kidney.

For Radiographs: Kodak Blue Brand X-ray Film and Kodak x-ray processing chemicals meet the most exacting requirements. They are always dependable—uniform. Quality controlled—rigidly tested—they are *made to work together.*

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Basic Procedures in the

Ear, Nose and Throat Operating Room

4 DENTAL SURGERY

GLADYS S. BLIZZARD, R.N.
Des Moines, Iowa

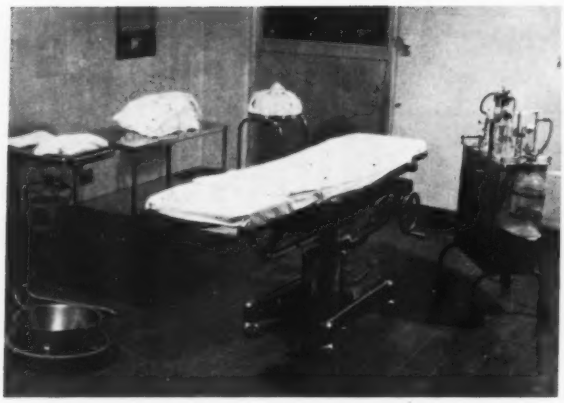


Fig. 20. Operating room ready for dental surgery.

THIS is the concluding article in a series, which began in the November 1953 issue of this magazine, to guide student and graduate nurses in circulating efficiently in ear, nose and throat surgery. The pictures and notes are basic setups and must be varied for the individual doctor doing the surgery, according to his preferences. Only the procedures most frequently performed at Wesley Memorial Hospital, Chicago, are given; however, these are basic and can easily be used as a guide in other E.N.T. setups, the changes being made according to the operation.

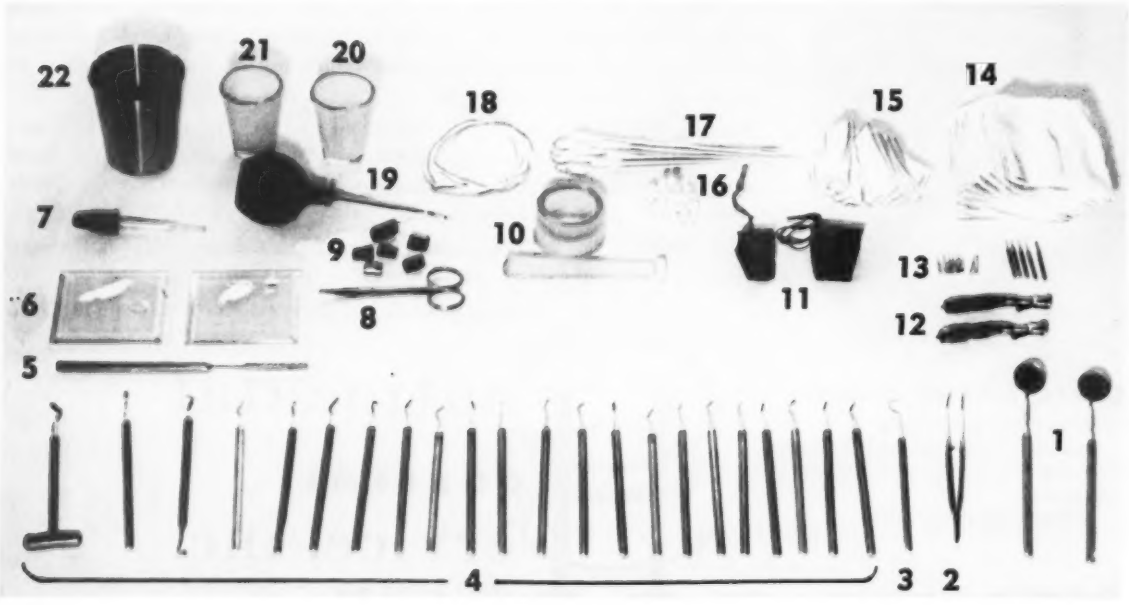
The article in the November 1953 issue presented basic setups for tonsillectomy and adenoidectomy; subsequent articles covered plastic surgery (December 1953), and endoscopy (January 1954).

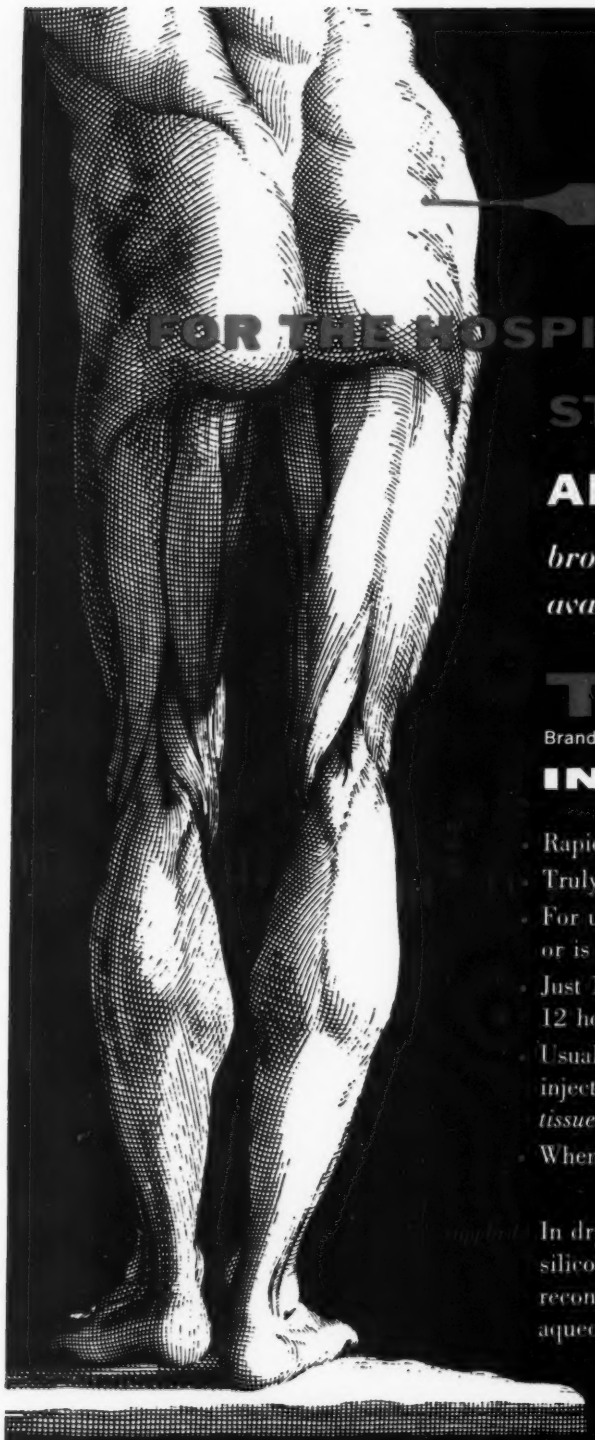
(*Continued on Page* 116)

KEY TO FIG. 21

1. Dental mirrors
2. Cotton forceps
3. Explorer
4. Instruments selected by doctor for each case
5. Spatula
6. Glass plates for cement
7. Medicine dropper
8. Wire scissors
9. Copper rings
10. Mortar and pestle
11. Bite blocks
12. Drill handles
13. Drill points
14. 4 x 4's
15. Brain sponges
16. Cotton pledgets
17. Cotton applicators
18. Amalgam paper
19. Air syringe
20. Glass for saline
21. Glass for adrenalin
22. Cup for alcohol

Fig. 21. Mayo table setup for dental surgery, showing various instruments.





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DENTAL SURGERY

Dental surgery is done in the operating room when there is a lot of dental work to be done and the patient wants it done in one procedure, or if the patients, particularly children, are apprehensive and likely to be uncooperative.

Equipment: (Fig. 20)

Room setup
- O.R. table
- Back table
- Mayo table
- Single ring stand
- Kick basin
- Light (overhead O.R. lamp)
- Drill (foot pumped)

Sterile supplies:

E.N.T. pack (containing 2 gowns and hand towels, 2 sheets, 6 towels, 2 pkgs. 4x4's, 1 MTC)

Gloves
Brain sponges
Cotton applicators
Stockinette
Copper rings
Drill handle
Drill points
- Silver
- Mercury

Amalgam
CaOH
Zinc Oxide
Cement

Instruments: (Fig. 21)

The basic set of instruments is autoclaved for 10 minutes and the more delicate instruments, probes, scrapers, mirrors and so on, are soaked for 30 minutes in 70 per cent alcohol.

The instruments are selected according to the doctor's preference and depend upon the type of procedure.

Drape:

The drill is draped in the following manner:

The tip is wiped with a sponge of 70 per cent alcohol. The scrub nurse unrolls sterile stockinette over the drill arm and fastens the stockinette at the end with a rubber band. The circulating nurse securely pins the other end to keep the stockinette from slipping off.

The patient is draped by the scrub nurse after the anesthetic is given. One sheet covers the patient from the chin to the foot, and one towel is opened and placed across the chest and well under the chin.

Room Setup During the Case:

The room setup is the same as for plastic surgery. The drill, if used, is at the right of the doctor.

Procedure:

The exact procedure depends upon the type of dental work to be done, first filling and then extracting.

Cleanup:

Clean the patient's face with water and change his gown if necessary.

Wash the instruments in a solvent solution, giving special attention to the drill points; to clean them well use a bur cleaner solution and dry them carefully to prevent rusting. Clean and straighten the room in the routine manner.

Here's a suture that's ready to use

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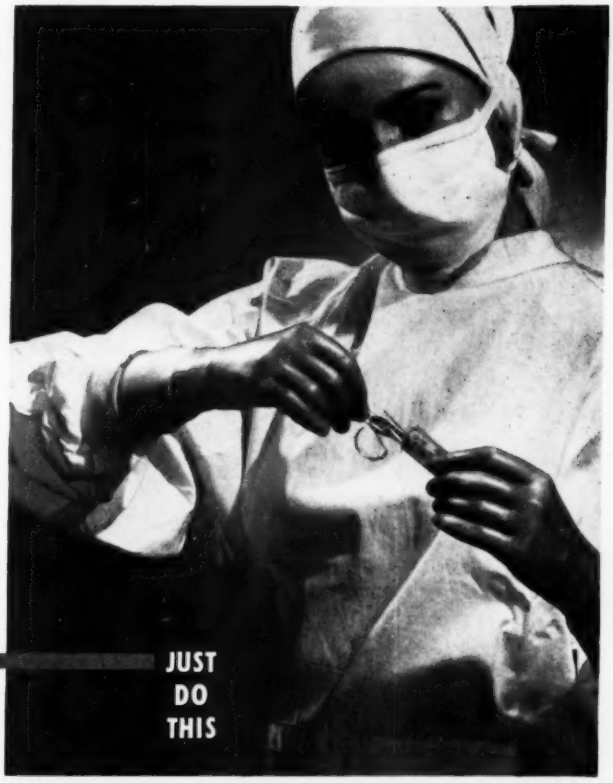

Curity Catgut Sutures streamline operating room procedure because they needn't be soaked or dipped before use.

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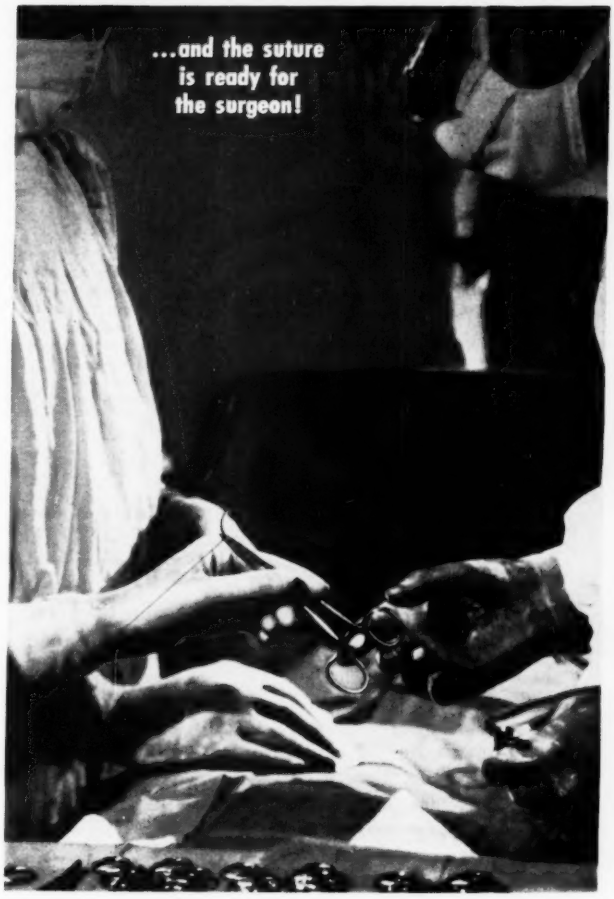

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How to Make the Most of Frozen Foods

FLORENCE MERRIAM
Washington, D.C.

WHAT are the advantages of using frozen foods? How should frozen foods be handled and prepared to get greatest possible value? What factors are involved in determining the amount of storage required by a hospital using frozen foods? These are some of the questions that come to mind when the use of frozen foods in hospitals is under consideration. The purpose here will be to answer these and other questions concerning the use of frozen fruits and vegetables that have particular significance to those responsible for hospital feeding programs. While some of these questions can be answered specifically, others must be treated in general terms, inasmuch as the size and location of individual hospitals, their equipment and particular situation vary widely. In any event, there is no doubt that frozen foods have a definite place in most hospitals.

The advantages of frozen foods are legion, and many of these advantages have particular application to hospital usage. First, consideration of cost factors will reveal (perhaps surprisingly) that frozen foods compare favorably with competitive products. Government statistics reveal that during the last several years, frozen food prices generally have declined much more than have those of fresh or canned fruits and vegetables.

In the data in Table 1, it will be noted, for example, that wholesale prices of frozen fruits and juices in October 1953 were about 9 per cent below their average in 1947-49; while at the same time wholesale prices of canned fruits and juices increased about 9 per cent and fresh fruits increased 15 per cent. Similarly, wholesale prices of frozen vegetables declined about 19 per cent, canned vegetables and soups increased 5 per cent, and fresh vegetables declined about 17 per cent. (The wholesale price indexes in Table 1 are based on the years 1947-49=100, and the figures in June 1950 are given for comparison, since they represent prices just prior to the Korean conflict.)

Aside from price, several other cost factors add to the advantage of using frozen foods. For example, it should be remembered that there is no waste in the frozen package or tin. Each package contains 100 per cent edible food; this means, of course, that the user is not paying for pods, seeds and extra stems, to say nothing of bruised or partially spoiled pieces of food.

The data in Table 2 illustrate this point. Such items as asparagus, lima beans, cauliflower, cut corn, and peas have more than a 50 per cent peeling and trimming loss. This means, for

Table 1—Wholesale Price Indexes (1947-49=100)

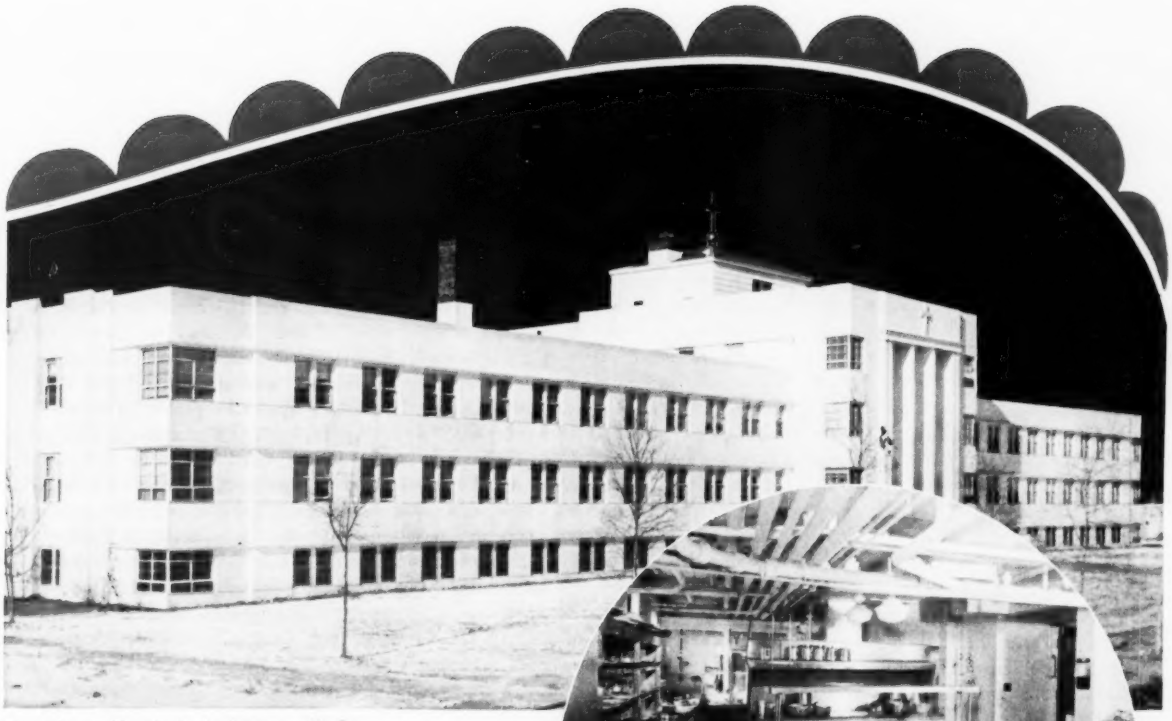
Product	October 1953	June 1950
Frozen fruits and juices	91.0	102.3
Canned fruits and juices	109.4	100.1
Fresh fruits	115.3	99.2
Frozen vegetables	81.2	95.5
Canned vegetables and soups	105.0	96.7
Fresh vegetables	83.4	84.3

Source: Prepared by National Association of Frozen Food Packers on the basis of figures published by the U. S. Bureau of Labor Statistics.

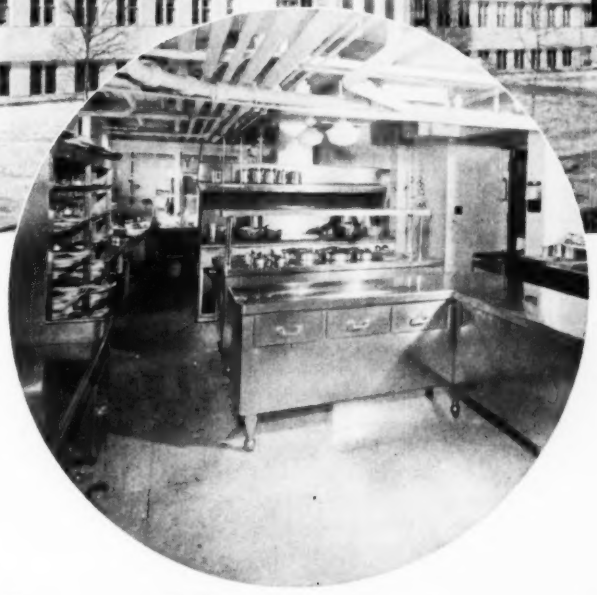
Table 2—Relationship Between Weights of Frozen and Fresh Vegetables

	Frozen	Approximate Fresh Equivalent	
Product	Weight Pounds	Average Trimming and Peeling Loss	Weight Pounds
Asparagus	2½	54%	5 to 5½
Beans, green and wax	2½	25%	3 to 3½
Beans, lima	2½	63%	6 to 6¾
Broccoli	2	45%	3½ to 3¾
Brussels sprouts	2	45%	3½ to 3¾
Cauliflower	2	70%	6½ to 7
Cut corn	2½	76%	10 to 10½
Peas	2½	60%	6 to 6¼
Spinach	2½	45%	4½ to 4¾

Source: Prepared by National Association of Frozen Food Packers on the basis of figures published by the U. S. Department of Agriculture.



Providence Hospital, Anchorage, Alaska



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example, that to obtain the same volume of peas contained in a 2½ pound package of frozen peas, it would be necessary to purchase approximately 6 pounds of fresh peas.

A further important point in considering cost factors is that frozen foods require a minimum of preparation labor. It is not necessary to pay a laborer for endless hours of washing, hulling, sorting and cutting. An excellent example of a labor saving item is frozen concentrated orange juice. Compare the time it takes to reconstitute a can of frozen juice against the time required to squeeze oranges giving an equivalent amount of juice. With the present high cost of labor, one can readily imagine that reduced labor cost in itself can be a great saving in total cost of an item.

EDIBLE PORTION KNOWN

A related advantage of frozen food in this connection is that when the total edible portion is known in advance, the problems of portion control and individual unit costs are greatly simplified. For example, once the number of servings obtained from a 2½ pound package of frozen peas is determined, this size package of frozen peas can always be counted on to provide the same number of servings.

It should be remembered, too, that out-of-season buying of fruits and vegetables may be possible at considerable savings with frozen foods. Many times these savings are possible even during "in season" purchasing, on the basis of such factors as less waste, reduced labor costs, and so forth. Regardless of cost, however, an additional advantage of frozen foods is their availability at any time they are wanted.

Dietitians and chefs who are concerned with serving foods of high quality, good flavor, attractive appearance and highest nutritive value are strong boosters of frozen foods. A great effort on the part of the packer of frozen items is expended to see that fruits and vegetables are harvested at their peak of quality, rushed to the packing plants, and then quick-frozen within a matter of hours. The purpose of this effort, of course, is to ensure high quality products.

Another outstanding advantage of frozen foods is their versatility. There is no need to limit the use of frozen fruits and vegetables to serving them as a single fruit or vegetable dish. Frozen vegetables, for example, can be used in a wide variety of recipes, such as salads, casserole dishes, soups and vegetable plate combinations. Frozen fruits and berries can be used in pies and dumplings, in both salad plates and molded salads, in ice creams and sherbets, or as toppings for cake, puddings or ice cream. The frozen juice concentrates also offer limitless possibilities.

Frozen fruits, vegetables and juices in general have excellent nutritional qualifications. Complete data on nutrients in frozen foods are not available, but those which have been developed suggest that in all respects the frozen products are generally equal or superior to their counterparts in fresh or processed forms. Surveys by the National Association of Frozen Food Packers show, for example, that vitamin C in frozen concentrated orange juice is equal to that of the freshly squeezed juice from which the concentrate was produced. Other surveys show that vitamin C in frozen orange juice averages higher than that in freshly squeezed juice with both the frozen concentrated juice and the fresh oranges being purchased at the retail market.

Because of the lack of complete data, the industry is now proceeding with a broad program of nutritional research aimed at developing comprehensive data on the exact components of every item of frozen fruits, vegetables and juices. As phases of this program are completed, frozen food nutritional data will be made available generally.

There are some important rules that hospitals should follow to obtain maximum value from the advantages of frozen foods. Hospital personnel should pay attention to proper handling and preparation of these products. Proper handling is required to prevent losses in flavor, appearance and nutritional values. By proper handling is meant that frozen foods should, to the greatest extent possible, be kept at all times under refrigeration at 0°F. or lower. This means that when frozen food orders are delivered, they should be placed in zero storage space immediately and not allowed to stand for an hour or so at room temperature. They should be kept in 0°F. storage until they are to be used.

It is also recommended that the principle of first in, first out should be followed. In other words, as a supply of frozen foods is received, the new packages should be placed in back of, or under, the foods already in storage. In this way, there would be no possibility of a few packages of frozen foods inadvertently being left in storage over an unusually long period of time.

This is not to imply that a rapid turnover of frozen foods is required to prevent deterioration of quality. Actually, most frozen foods, properly packaged and held at 0°F., can be kept up to a year, and in some cases much longer, with no adverse effect on the quality of the product. (See Table 3.) Nevertheless, simply as a practical matter of good housekeeping, it is believed that the first in, first out principle should be followed. This precludes even a slight possibility of stray packages being lost in the shuffle and being held in storage for two or three years. Especially in cases where large storage space is involved, such a situation could develop if good habits of storage are not constantly followed.

There also are some simple but important rules to follow in the cooking of frozen vegetables. For best results, these recommendations should be followed: (1) cook in small amounts; (2) cook in small quantities of water, and (3) cook for short periods of

Table 3—Storage Life of Frozen Foods

(Average life in good condition at various temperatures for normally packed and packaged items)

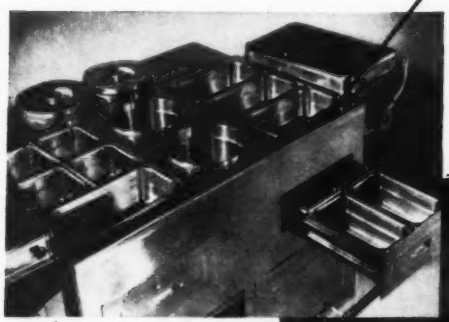
	0° F. Months		0° F. Months
*Apricots	18-24	Fish, fatty	6- 8
Asparagus	8-12	Fish, lean	10-12
Beans, green	8-12	Lobsters	8-10
Beans, lima	14-16	*Peaches	18-24
Broccoli	14-16	Peas	14-16
Brussels sprouts	8-12	Raspberries, sugared	18
Cauliflower	14-16	Spinach	14-16
Corn, on-cob	8-10	Strawberries, sliced	18
Corn, cut	24		
Carrots	24		

*With ascorbic acid.
Source: Dr. Donald K. Tressler in "Quick Frozen Foods" magazine, New York City, March 1953.

one food conveyor gives you dozens of inset arrangements for your selective menus

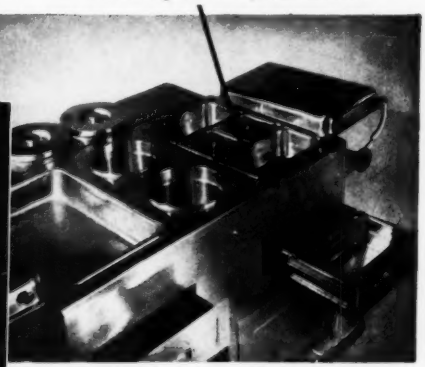
This new electrically-heated food conveyor is designed specifically for selective menus. It will contribute to successful diet-therapy in your hospital. Eighteen insets in various sizes can be placed in the wells in different combinations. These provide innumerable top deck arrangements to meet the requirements of any given meal. In addition to the two rectangular wells, there are two round wells for soup and broth and two heated drawers for special diets and rolls. The entire unit is made of heavy-gauge corrosion-resistant stainless steel. Top and body are of seamless, crevice-free construction, meeting the strictest hospital standards for sanitation and durability. If you're contemplating the "selective menu" idea, write for information about Model ALS-4922.

▲ EIGHTEEN square and rectangular stainless steel insets in various sizes can be arranged in many combinations.

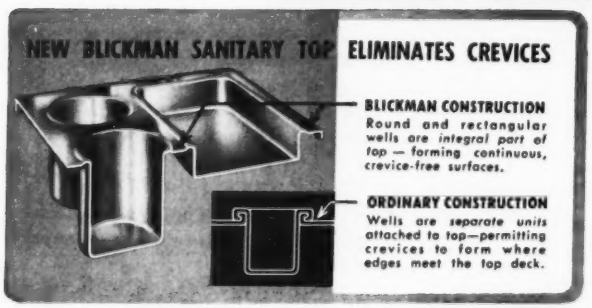


▲ *Above:* Today's menu may call for four square and four rectangular insets as shown here

Right: While tomorrow, square and rectangular insets may be arranged like this. ▶



▲ *Above:* Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.



SEND FOR ILLUSTRATED BOOK

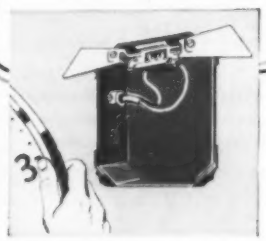
explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.

Blickman-Built
Hospital Equipment

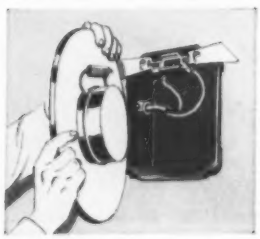
S. BLICKMAN, INC., 1503 GREGORY AVENUE, WEEHAWKEN, N. J.

See the catalog of Blickman-Built Food Conveyors in the Hospital Purchasing File.

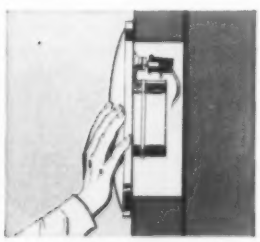
You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 29-31 and to the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., Booths No. 28-29-30, April 7-9.



Wall outlet pre-wired, permanently installed.



Clock plugs easily into outlet.



Clock securely mounted, yet easily removed.

● This ultra-thin Faraday clock incorporates design advances that greatly simplify installation and give it a distinctive beauty, unmatched in clocks of flush design. It is installed, securely and easily, by plugging it into a pre-wired wall outlet—yet it can be removed from the wall with equal ease. Once installed, its polished aluminum rim projects *only* 7/16″—and actually *looks* as though it were mounted in the wall.

The Faraday Flush Clock is unusually easy to read—from many angles—because of its special flat center convex crystal and crisp black numerals against a white face. It is operated by a high-quality, impulse or synchronous movement. Available in a wide variety of standard diameters as individual synchronous clocks or as a part of a complete program system. Write for details.

*Patent applied for.

HOLTZER-CABOT **FARADAY** STANLEY & PATTERSON

CONSOLIDATED BY:

SPERTI FARADAY INC. ADRIAN, MICH.

BELLS · BUZZERS · HORNS · CHIMES · VISUAL AND AUDIBLE PAGING DEVICES AND SYSTEMS

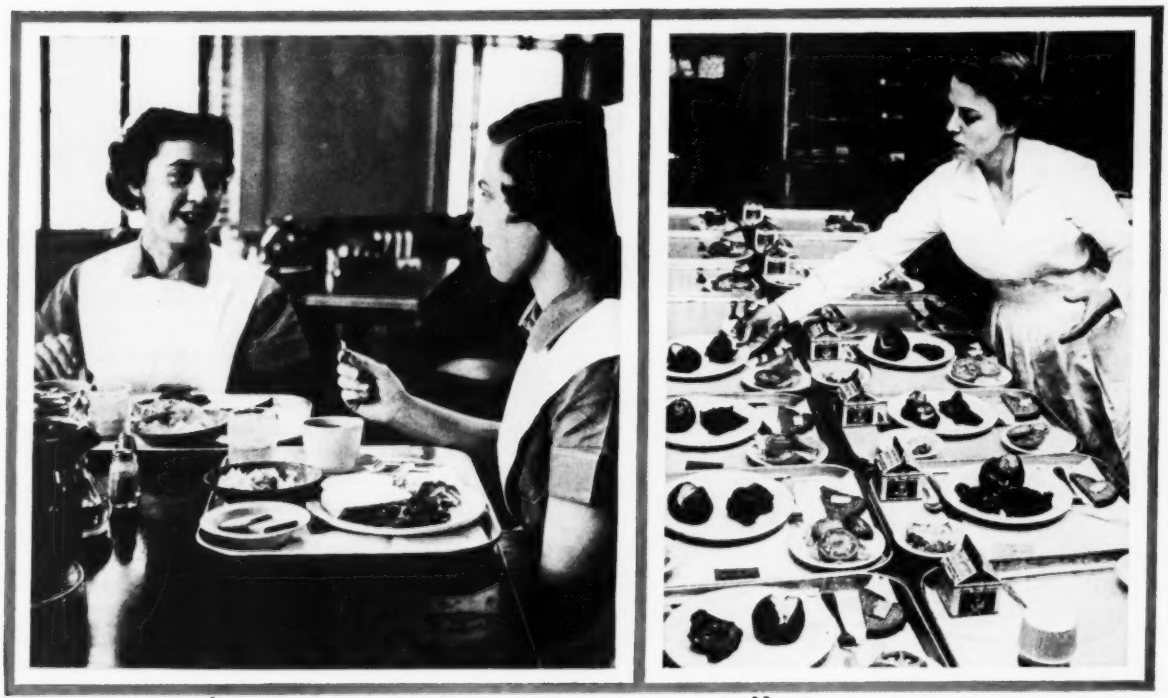
time. Observance of these rules will make an important contribution to retention of flavor, texture, color and nutritive values.

With the advantages available from the use of frozen foods, many hospitals undoubtedly would desire to expand their use of these products in menu planning but are limited because of restricted storage space. It is apparent that availability of storage space is a strategic factor so far as frozen foods are concerned.

This leads to a question that frequently arises: How much storage space is required by hospitals for frozen foods? This is, of course, a question that cannot be answered in specific terms, because there are too many variable factors relating to the situation of particular hospitals. For example, storage requirements will depend on such variables as: frequency of frozen food deliveries; how often frozen foods are included on the menu, and, obviously, the size and type of the hospital. Once these variables are established, it is possible to determine the amount of frozen foods which should be stored at the hospital. After arriving at this figure, the cubic feet of 0°F. storage space required by the hospital can be roughly determined on the basis of about 20 to 25 pounds of product per cubic foot of space. To repeat, it is imperative that this refrigeration equipment should be capable of holding this storage space at 0°F.

In summary, it is quite apparent that frozen foods have many inherent advantages that make these products ideal for hospital usage. They make it possible to exercise close portion control and unit costs, they eliminate much preparatory labor and reduce confusion and mess in the kitchen. Their cost compares favorably with that of competitive foods. They have special appeal in appearance and flavor, and available evidence indicates excellent nutritional qualifications. For hospitals to gain maximum value from frozen foods, diligent efforts must be devoted to proper handling and cooking. Storage should be at 0°F. or lower. Hospitals with questions as to amount of storage space needed can develop generally accurate quantitative data by determining the number of pounds of frozen foods to be stored, and estimating cubic feet of space needed on the basis of approximately 20 to 25 pounds of frozen foods per cubic foot of space.

BREAK-RESISTANT MELMAC® DINNERWARE



IS AN "HONOR GRAD" AT GRADY!

GRADY MEMORIAL HOSPITAL, ATLANTA, GA.

First admitted for study in 1948 . . . tested alongside conventional types . . . dinnerware made of Melmac molding material demonstrated such a low breakage record, such excellent washability, such lasting good looks—that it's now tops with Grady Memorial Hospital. And few replacements due to breakage have been necessary in over a year!

"Just what the doctor ordered" to perk up languid appetites at many hospitals is Melmac . . . the dinnerware of the tempting colors, the soft, rich luster. And hospital-right Melmac stacks with a whisper, is the biggest boon to hospital Q-U-I-E-T since the advent of rubber tires.

Why, even the help get a lift every time they lift Melmac dinnerware. It's so amazingly light – yet it looks as substantial as a board chairman!

Better ask your supplier about Melmac dinnerware *today* . . . and write us for the illustrated booklet, *Of Melmac Dinnerware.*

AMERICAN Cyanamid COMPANY

PLASTICS AND RESINS DIVISION
34F ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

In Canada: **NORTH AMERICAN CYANAMID LIMITED**
Royal Bank Building, Toronto, Ontario
5550 Royalmount Avenue, Montreal, Quebec

Melmac is a registered trade-mark of American Cyanamid Company, New York 20, N. Y., for Melmac Molding Compounds used in the manufacture of dinnerware and other modern products.

FOOD FOR THOUGHT

Electric Cord Care

Electric repair shops often report that their biggest business is in repairing damaged appliance cords. Many cord casualties result from the unfortunate practice of pulling on the cord rather than the plug when the appliance is disconnected. This eventually loosens the wire from the plug. Here's how to disconnect: If there is a switch at the outlet, turn it off before you pull the plug. This prevents sparking between metal prongs and outlet, which damages metal and in time causes a poor connection. If there's no switch, disconnect plug from wall outlet first. Grasp the plug and pull straight. If the plug sticks, rock gently from side to side as you pull to loosen one connection at a time. It is wise to disconnect cord from outlet each time you finish using a heating appliance.

When cords are not in use, keep them in a clean, dry, cool place. A permanently attached cord may be wrapped around the appliance loosely, but make sure the appliance is cool.

Keep cords free from kinks, knots or sharp bends which can break fine wires or insulated covering. Cords may hang over large, round wooden pegs, or over two or more hooks, or they may be coiled loosely.

Diets to Prevent Decline

For less decline in the so-called "declining years," better food habits are recommended by home economists of the U.S. Department of Agriculture. As people live longer, they need to give more consideration to diets that will make those extra years healthier and thus happier and more useful. Middle-aged persons especially should check on what they eat to have diets that will prepare them for healthier later years. But even the elderly often can do much for themselves by learning what foods they need and why.

As research has shown that food has much to do with many of the chronic ills common among the elderly, more attention is being given to diets that will stave off these conditions. A nutritionally adequate diet for the elderly is similar to that for any adult. First, emphasis should be on foods supplying nutrients for repair and upkeep of the body. Then other foods can be added as needed to meet energy needs. Because elderly people are less active than younger adults, they need fewer foods solely for energy. But their need for *protein, minerals and vitamins* is the same or even greater. Thus, from middle age onwards, well balanced diets should include generous amounts of milk and milk products, lean meat, poultry, fish and eggs as well as vegetables and fruits, especially leafy green and yellow vegetables and tomatoes and citrus fruits.

The nutritional problems common among the elderly deserve greater understanding today when more than 8 per cent of our population is over the age of 65 years. Three basic reasons for these problems are: poor food habits of long standing; low incomes; effect on appetite and food intake of difficult adjustments often required during this period of life.

New ALVEY-FERGUSON
POT and PAN WASHER

Now With The
AMAZING ELECTRONIC TIMER!

YOU HAVE NEVER seen anything like it! . . . kitchen equipment that will *mechanically, automatically* and economically *sterilize* as well as *clean* all pots, baking pans, roasting pans, steam table pans, pie tins, kettles and utensils—even 80 qt. mixing bowls and garbage pails . . . The uniform washing operation is performed at an elevated temperature to provide cleanliness and sterilization.

These new A-F Pot and Pan Washers—Model BK—have 5 other unique superiorities including an amazing electronic timer that provides the proper "wash-drain-rinse" cycle. No time lost in operation and yet, even stubborn residue is removed.

New Model BK Amazingly compact! Occupies floor space only 3'4" x 5'2". New adjustable feet . . . sanitary, vermin proof . . . 6" clearance for easy cleaning beneath machine.

Furnished for Gas Steam or Electric Heating

Write for New, Free Booklet describing A-F Model BK—today!

THE ALVEY-FERGUSON CO.
Representatives in Principal Cities
216 Disney Street Established 1901 Cincinnati 9, Ohio

Engineers and Manufacturers of A-F Kitchen Conveying Systems, Pot and Pan Washing Machines and Bakery Rack Washers.

Dietitian Vivienne Nemlich, of the Tulare County General Hospital, wrote us about the various jobs Lily* Cups and Containers perform for her. We thought you might be interested in seeing the letter.

Could it be that Lily can do as much for you? Remember, there is hardly a food service problem that Lily can't help solve. Our sample "Hospital Kit" carries all the details. We'll send it, without obligation, if you'll drop us a note on your letterhead.

How many duties can LILY perform in your Hospital?

ELMO ZUMWALT, M. D.
MEDICAL DIRECTOR

COUNTY OF TULARE
STATE OF CALIFORNIA

TULARE COUNTY GENERAL HOSPITAL
TULARE, CALIFORNIA

JAMES W. McFARLANE
ADMINISTRATOR

Lily-Tulip Cup Corporation
122 East 42nd Street
New York 17, N. Y.

November 20, 1953

Gentlemen:

We are pleased with our Lily Cups and as time goes on find more and more uses for them.

We have a small isolated area where we use all-paper service and save many hours of work because both sterilization and dish-washing are eliminated.

In our regular service, we use the #67 cold drink cup for fruit juices and other cold beverages. The souffle cups in assorted sizes are ideal for jellies, apple sauce, tartar sauce, etc.

We are fortunate in having plenty of deep freeze space and we use Lily containers to freeze sauces, chili, concentrated soups, chow mein, etc.

As time goes on, we find more and more uses for paper service and we like it.

Sincerely yours,

Vivienne Nemlich

'N:HH

Vivienne Nemlich
Dietitian

Lily® cups

LILY-TULIP CUP CORPORATION
122 East 42nd Street
New York 17, New York

Chicago • Kansas City • Los Angeles
San Francisco • Seattle
Toronto, Canada

*T.M. Reg. U.S. Pat. Off.

Menus for April 1954

1 Grapefruit Half Popovers • Liver and Bacon With Ketchup Hashed Brown Potatoes Creamed Onions Lettuce With Russian Dressing Spice Cake • Cream of Mushroom Soup Barbecued Wieners Hot Biscuits Celery and Cabbage Salad Baked Apple With Cream	**2** Cantaloupe French Toast, Sirup • Baked Haddock, Tartare Sauce Parsley Buttered Potatoes Baked Squash Jellied Cranberry Salad Pecan Crunch Ice Cream • Tomato Bouillon Egg Salad and Pickle Sandwiches Mixed Fruit Salad Butterscotch Marshmallow Pudding	**3** Orange Juice Soft Cooked Egg • Roast Lamb With Mint Jelly Oven Browned Potatoes With Gravy Buttered Carrots Sliced Tomato and Cucumber Salad Chocolate Marshmallow Roll • Cream of Asparagus Soup Link Sausages Escalloped Corn Cinnamon Apple Salad Hermits	**4** Grapefruit Half Bran Muffins, Jelly • Southern Fried Chicken With Cranberry Sauce Mashed Potatoes With Gravy Buttered Peas Celery and Olives Butterscotch Sundae • Vegetable Soup Tuna Salad Potato Chips Melon Slices Hot Rolls Fresh Fruit Cup Vanilla Wafers	**5** Sliced Bananas Bacon Strips • Swiss Steak With Gravy Parslied Potatoes Cauliflower Combination Salad With French Dressing Blackberry Cobbler • Clam Chowder (large) Deviled Egg With Pickled Beet Salad Coffee Soufflé	**6** Blended Juice Cinnamon Rolls • Meat Loaf With Ketchup Baked Potato String Beans Apple and Celery Salad Cottage Pudding With Orange Sauce • Scotch Broth Escalloped Potatoes and Frankfurters Tomato and Avocado Salad Canned Plums
7 Orange Slices Poached Egg • Pork Chops With Apple Rings Mashed Potatoes With Gravy Whole Kernel Corn Perfection Salad Graham Cracker Pudding • Cream of Pea Soup Hamburger With Bun Carrot and Raisin Salad Fresh Pear	**8** Cantaloupe Griddle Cakes, Sirup • Roast Beef Oven Brown Potatoes With Gravy Creamed Celery Lettuce With French Dressing Bread Pudding With Caramel Sauce • Vegetable Soup Chow Mein Noodles Mixed Fruit Salad Cup Cake	**9** Grapefruit Juice Scrambled Eggs • Fillet of Sole With Tartare Sauce Escalloped Potatoes Fresh Spinach Tomato and Lettuce Salad Banana Cream Pie • Cream of Corn Soup Cheese Soufflé Tossed Garden Salad Baked Apple With Cream	**10** Tokay Grapes Link Sausages • Lamb Chops With Pickle Relish Hashed Brown Potatoes Baked Squash Melon Slices Tapioca Pudding • Cream of Asparagus Soup Italian Spaghetti With Meat Balls Coleslaw Canned Apricots	**11** Tomato Juice Popovers • Baked Ham With Mustard Sauce Candied Yams Buttered Broccoli Grapefruit and Orange Section Salad, French Dressing Chocolate Sundae • Beef Broth With Rice Creamed Chicken on Hot Biscuits Watercress and Sliced Cucumber Salad Bing Cherries	**12** Stewed Prunes Soft Cooked Egg • Braised Beef With Horseradish Buttered Noodles Parslied Carrots Lettuce Wedge With Russian Dressing Boston Cream Pie • Split Pea Soup Fresh Fruit Plate With Cottage Cheese Hard Rolls Gelatin Cubes With Whipped Cream
13 Grapefruit Half Sweet Rolls • Roast Veal With Dressing Spiced Pears Mashed Potatoes With Gravy Julienne Beets Apple, Celery and Date Salad Grapenut Custard • Mulligatawny Soup Meat Loaf in Biscuit Crust With Gravy Banana Nut Salad Lime Sherbet Wafers	**14** Orange Juice Poached Egg • Braised Liver With Ketchup Creamed Potatoes Buttered Asparagus Sunset Salad Raspberry Shortcake With Whipped Cream • Consommé Baked Ham and Lima Beans Spring Salad With French Dressing Cornbread Pineapple Chunks	**15** Cantaloupe Bacon Strips • Roast Beef Browned Potatoes With Gravy Escalloped Cabbage Tomato and Lettuce Salad Apricot Whip • Cream of Mushroom Soup Shepherd's Pie Frozen Fruit Salad Gingerbread	**16** Grapefruit Juice Blueberry Muffins, Jelly • Salmon Steaks With Lemon Wedge Baked Stuffed Potato Buttered Peas Sliced Orange and Coconut Salad Peppermint Stick Ice Cream • Lakeside Soup Grilled Cheese Sandwich Asparagus and Pimiento Salad Baked Apple With Cream	**17** Sliced Banana Scrambled Eggs • Swedish Meat Balls Parslied Buttered Potatoes Mashed Squash Lettuce Wedge With 1000 Island Dressing Pineapple Upside-Down Cake With Whipped Cream • Beef Broth With Vermicelli Vegetable Casserole Veal Salad Fruit Cup Date Bars	**18** Orange Slices Country Sausage • Roast Chicken With Sage Dressing Cranberry Relish Mashed Potatoes, Gravy Green String Beans Stuffed Celery Cherry Pie • Cream of Corn Soup Cold Sliced Meat Potato Salad Tomato Slices Hot Rolls Sliced Peaches
19 Pineapple Juice Griddle Cakes, Sirup • Stuffed Pork Chop With Spiced Crabapple Escalloped Potatoes Mashed Turnips Tossed Green Salad Fruit Marshmallow • Vegetable Soup Baked Tuna With Potato Chips Grapefruit Sections With Apple Slices Oatmeal Cookies	**20** Stewed Prunes Ham Omelet • Beef Stew With Carrots and Onions Boiled Potatoes Buttered Cauliflower Melon Slices Steamed Pudding With Hard Sauce • Chicken Soup With Rice Hot Roast Beef Sandwich With Gravy Celery, Radishes and Green Pepper Rings Seedless Grapes	**21** Grapefruit Half Date Muffins • Roast Lamb With Mint Sauce Mashed Potatoes With Gravy Whole Kernel Corn Tomato Wedges Blueberry Cobbler • Oyster Stew (large) Bacon and Cheese Sandwich Pineapple and Banana Salad Brownies	**22** Orange Juice Bacon Strips • Swiss Steak With Gravy Pan Browned Potatoes Broccoli Waldorf Salad Floating Island • Cream of Pea Soup Stuffed Peppers Combination Salad Fresh Plums	**23** Honey Dew Melon Soft Cooked Egg • Fried Mackerel With Lemon Wedge Baked Potato Harvard Beets Pear With Grated Cheese Salad Chocolate Meringue Pie • Salmon Loaf With Parsley Sauce Red Cabbage Slaw Canned Apricots Macaroons	**24** Tomato Juice Coffee Cake • Chicken Pie Mashed Potatoes Buttered Peas Stuffed Celery Apple Goody • Beef Broth With Noodles Omelet With Spanish Sauce Sliced Banana and Orange Salad Coconut Cake
25 Cantaloupe Link Sausages • Broiled Steak With Pickle Relish Hashed Brown Potatoes Julienne Carrots Lettuce Wedge With Roquefort Dressing Strawberry Sundae • Corn Chowder (large) Assorted Cold Meats Celery Hearts Cooked Vegetable Salad With French Dressing Hard Rolls Date Bars	**26** Blended Juice Poached Egg • Roast Beef Mashed Potatoes With Gravy Browned Parsnips Lettuce and Tomato Salad Baked Lemon Sponge • Vegetable Soup Chop Suey Rice Frozen Fruit Salad Toll House Cookies	**27** Sliced Banana Cornmeal Muffins, Honey • Breaded Veal Chops Baked Potato Mashed Squash Cucumber in Lime Gelatin Salad Fresh Peach Shortcake With Whipped Cream • Chicken Soup Cheese Dreams Melon Ball Salad Baked Custard	**28** Tokay Grapes Griddle Cakes, Sirup • Meat Loaf With Pepper Relish Escalloped Potatoes Green String Beans Apple, Celery and Date Salad White Cake • Cream of Tomato Soup Baked Chicken and Noodles Grapefruit and Avocado Salad With French Dressing Mocha Soufflé	**29** Orange Juice Bacon Strips • Roast Pork With Applesauce Candied Yams Spinach Celery and Olives Rice Pudding With Raisins • Mulligatawny Soup Baked Hash With Ketchup Jellied Spiced Banana Salad Coconut Cream Pie	**30** Stewed Prunes Scrambled Eggs • Codfish Balls With Sauce Parslied Buttered Potatoes Whole Kernel Corn Tossed Green Salad Lemon Sherbet Sugar Cookies • Clam Bisque Baked Potato Grilled Tomato Asparagus Tips Apricot With Cottage Cheese Salad Brownies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Only PC's*, give you these 4 portion-control* advantages

Kraft PC Packs

Finest jams, jellies and table syrup in individual plastic containers

If you want to serve top-quality jams, jellies and table syrup without waste or bother, take advantage of Kraft PC Packs. PC's four portion-control features explain why they are being served by more and more hotels, restaurants, railroads and airlines throughout the nation.

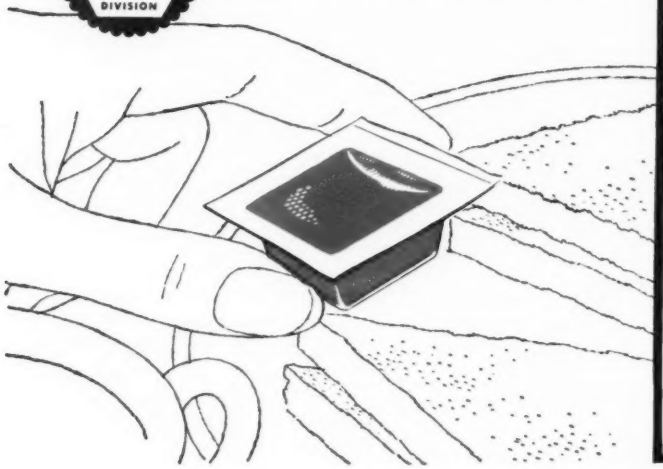
jams and jellies available in ½-oz. size in 6 popular varieties:

GRAPE JELLY • APPLE JELLY • ORANGE MARMALADE
STRAWBERRY JAM • CURRANT JELLY • CRANBERRY SAUCE

Maple-flavored Table Syrup available in 1¾-oz. size

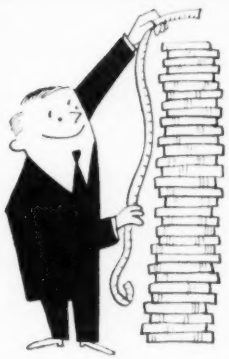
KRAFT Foods Company INSTITUTIONAL DIVISION

THE NATION'S TASTE IS YOUR BEST BUYING GUIDE



Convenient

No work involved with PC's—all you have to do is place it on the plate. It reaches customer in neat, sanitary condition.

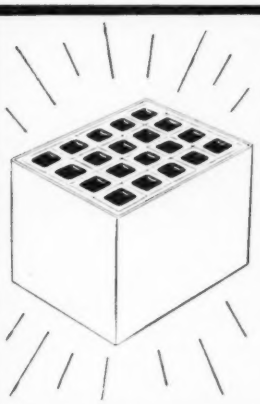


Measured Costs

No labor costs or waste of employees' time. You can always tell how many servings you have on hand. Costs can be measured to the penny.

Exact Servings

Each PC is a just-right serving . . . not too skimpy to cause customer complaints. Not too generous to cut into profits.



PACKED FOR Efficient Handling

PC's are packed 20 to a tray—10 trays to a carton. They're readily accessible . . . will store compactly in a minimum of space.

Economy and efficiency are provided by

Modern Pipeline Distribution

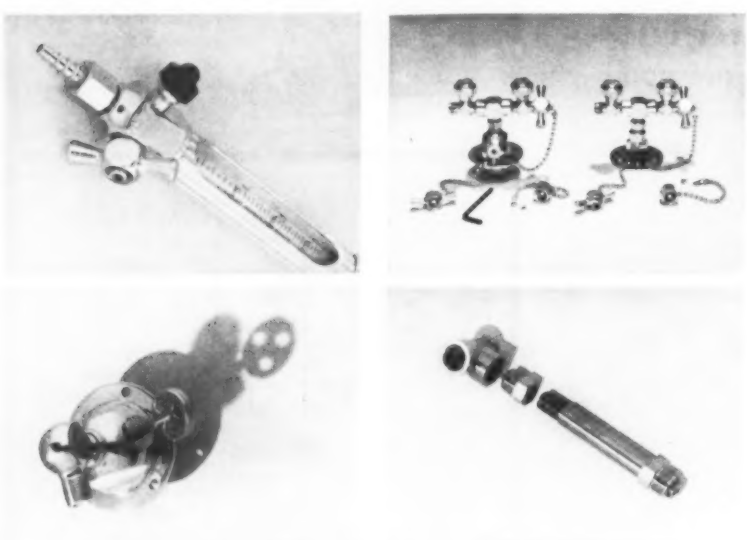
W. J. KRAMER
Assistant Director, Mount Zion Hospital, San Francisco

IF YOU employ cylinder gases in your hospital, you are using, or certainly should consider using, modern gas distribution by cylinder manifold and pipeline, instead of by individual cylinders.

The many advantages of pipeline distribution are well known to hospital administrators and engineers. Even if you use a small number of cylinders, a manifold of proper size will eliminate the need to have cylinders carried or rolled to various spots in your hospital. Instead of having to distribute individual cylinders which might fail to provide life-giving oxygen to a patient in a crisis, an ample quantity of oxygen is available at all times and at all points where it is needed. The patient need not be disturbed or worried when simple preparations are made to furnish oxygen from outlet stations. The arrival of cylinders, on the other hand, may cause entirely avoidable anxiety.

Furthermore, if the cost of handling individual cylinders—distributing them, gathering the empties, and checking their gas content—is considered, the initial investment in a cylinder manifold and pipeline distributing system justifies itself financially. When new buildings are planned, the oxygen storage room and the concealed pipeline distributing system with modern outlet stations are standard features today. It is not as widely recognized, however, that a modern pipeline distributing system can be installed rapidly and inexpensively even in older buildings. When you install such a system, two questions should have careful consideration. What quantity of gas will be required at peak consumption hours? What likelihood is there that the existing and foreseeable peak load might not prove adequate in the future? A well planned distributing system will be one which provides ample facilities for current peak loads and future expansion, without making the immediate installation more costly than it need be. Thus, cylinder manifolds should be extendable, and initial pipelines must be large enough in diameter to permit linear extension into new areas if hospital facilities are expanded.

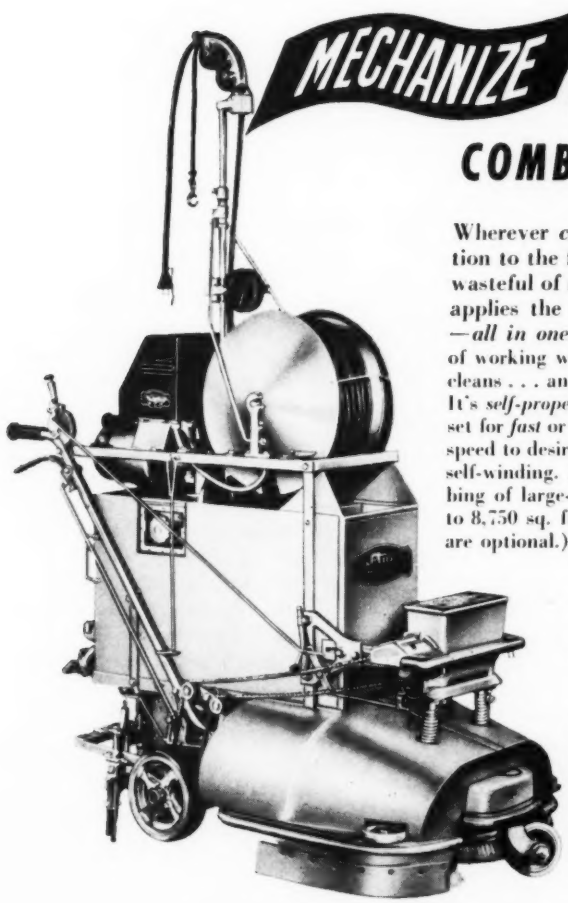
Outlet stations are equally important. In hospital rooms, consideration must be given to neat appearance of all exposed equipment and to the likelihood that outlet valves, regulators and other equipment must be handled by personnel with little or no training in the mechanical arts. Preferably, outlet valves should have built-in, concealed locks which may be closed or opened only by authorized personnel, while standard and visible valve handles function in the usual manner when the outlets are



Top, left: Oxygen flow meter equipped with rapid-fastening wing nut and micrometer-adjusting valve; right: various types of fittings for wall outlet stations. Bottom, left: Safety keyed wall outlet valve; right: new cylinder manifold design.

Illustrations, courtesy, National Welding Equipment Co., San Francisco.

Let's not clean away dollars and man-hours with costly, inadequate floor care



MECHANIZE your floor-cleaning with a COMBINATION SCRUBBER-VAC!

Wherever *combination-machine-scrubbing* is the practical solution to the floor-cleaning problem, any lesser, slower method is wasteful of money and manpower. A *Combination Scrubber-Vac* applies the cleanser, scrubs, flushes if required, and picks up —*all in one operation!* Maintenance men like the convenience of working with this single unit . . . the thoroughness with which it cleans . . . and the features that make the machine simple to operate. It's *self-propelled*, and has a *positive* clutch. There are no switches to set for *fast* or *slow*— slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs quietly. Cable reel is self-winding. *Model 213P Scrubber-Vac* at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread, and cleans up to 8,750 sq. ft. per hour! (Powder Dispenser and Level Cable Wind are optional.)

Finnell makes *Scrubber-Vac Machines* in a full range of sizes — for small, vast, and intermediate operations. From this complete line, you can choose the size that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac*, and that *a Finnell floor specialist and engineer is nearby* to help train your maintenance operators in the proper use of the machine . . . to recommend cleaning schedules for most effectual care . . . and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1403 East St., Elkhart, Ind. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

open. This arrangement precludes the accidental opening of valves, resulting in substantial loss of gas, and facilitates a simple means of controlling the gas used and subsequent oxygen charges to the patient.

Because cylinder manifolds are now being used so widely and for so many different cylinder gases in hospitals, laboratories and industrial plants, manifold design has been improved to meet changing needs. In the first place, cylinder manifolds may now be basically "tailor-made" from standard fittings. No two cylinder rooms are of identical size. No two gas requirements are precisely similar. Future expansion of one user might be vastly greater and more likely than that of another user. Manifold installations must, therefore, be made to fit individual requirements. However, the components have been so designed today that they can be fitted together with the simplicity of an erector set.

In the past, cylinder manifolds were usually soldered in the producer's plant. This necessitated careful packing to avoid strains during shipment, which might weaken or even break a joint. Unfortunately, however, even a well made and perfectly dependable soldered joint can be damaged by excessive lateral strain on the assembled manifold. This prevented the individual installer from making any kind of basic adjustment when the over-all length of the manifold failed to fit a given space or area. Finally, the eventual extension of these manifolds often proved difficult.

Nevertheless, if oxygen at its high initial pressure is to be distributed by pipeline it is absolutely essential that all joints between manifold parts be entirely dependable, safe and of maximum sturdiness. Cylinder manifold designs are now available which will permit anyone able to use simple tools dependably to assemble the entire structure right on the job; the joints fit together easily, and offer all the sturdiness of which cylinder manifold connections must be certain. These features permit unlimited extensions at future times and with equal simplicity. Shipping problems are simplified because component parts can be placed in boxes containing standardized parts. These parts will permit the installation of wall-type or stand-type manifolds with one or two or even a greater number of banks. They will permit the regulating control mechanisms to be located in the center or on either end of the cylinder bank, and the manifold can be placed either in straight line or in any angular direction. Control sections are so designed that it is possible to discharge one cylinder bank and then automatically have the control mechanism switch on the full bank, permitting the operator to exchange the now empty cylinders for full ones without at any time shutting down the gas supply.

If desirable, remote control gauges will indicate the pressure of any one of the cylinder banks, electric warning devices can be installed to call attention to the fact that one cylinder bank is now empty and requires replacement of cylinders, and if it is considered desirable and worthy of the added cost, master control regulators can be placed in a separate control room, which will permit increasing or decreasing the cylinder delivery pressures without ever going to the storage room.

Modern pipeline distribution of oxygen will permit as nearly automatic function as is safe and desirable, but a great deal of future disappointment and trouble can be avoided at the time the system is contemplated.

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How safe is your hospital?

International News Photo

Above: Fire in a mid-western hospital, out of control, destroys the building, takes the lives of forty patients.

This year there will be an average of three hospital fires reported per day and they will follow the general pattern shown in the insert.

Not all of these fires will develop into disasters, for most modern hospitals have excellent fire protection. But experience shows that some few will, and that these few will take an almost inevitable toll of lives and property. These will be hospitals not now provided with means of stopping fire *quickly at its source.*

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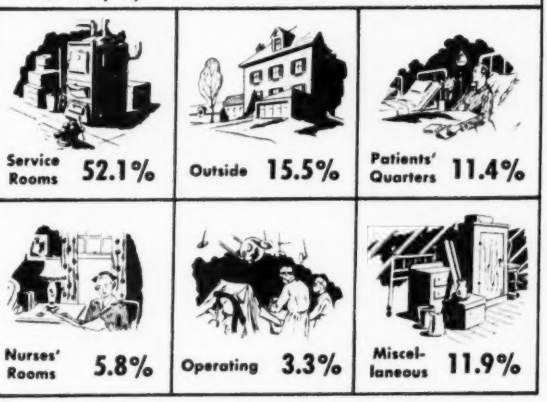
Here's Where Hospital Fires Start

(Survey by National Fire Protection Association)



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The V. A. Sets Up Housekeeping

TRAINING MANUAL ON WAXING—IV

FOUR Housekeeping Training Guides, covering sweeping, mopping, dusting and waxing, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the fourth section of the manual on waxing. The manuals on sweeping, mopping and dusting have been presented in successive months, beginning in the January 1953 issue of this magazine.—ED.

91. Wax-splashed walls and bases have always been one of the waxer's problems. When wax was crudely applied they have caused many an extra hour of work. Waxey's belief is "that prevention is easier than cure." He, therefore, applies his "edge-wax" with this special tool, which does not permit of splashing. It is used with only a nominal amount of wax upon it, and it cuts a clean edge. Waxey always starts the wax application with this edger tool.

92. Edge-areas of rooms do not require a heavy coating of wax, for there is little traffic along most edge-areas. It is only where the traffic is heavy that heavy applications of wax must be made.

Waxey avoids heavy build-up of wax along the edge-areas by only mildly saturating his edge-applicator. By so doing he avoids the necessity later on (when again stripping the floor) of having to run his stripping equipment close to the baseboards.

A particular advantage which this edge-applicator has over the old method of using a strand mop is that it is so easy to cut a clean edge with it, with no possible splashing. Before waxing any of the center area, Waxey carefully lays a thin film of wax all around the edges of the area. This partially dries while he later waxes the larger center area.

93. The gesture which Waxey is demonstrating here was a common one before the era of the block-type edger. Employes used to fill the mop with as much wax as it would hold . . . and just swish it all over the place. They never stopped to realize what damage they were doing. Waxey is too anxious to save himself extra work, to use this old-fashioned technic.

94. Waxey uses the strand applicator (the wet mop) *only* in the center, large or clear areas, where he is not likely to splash surrounding surfaces.

95. Like the other wax applicator which Waxey uses, this one, too, has to be spotlessly clean for wax application. It cannot be a mop which has previously been used for the

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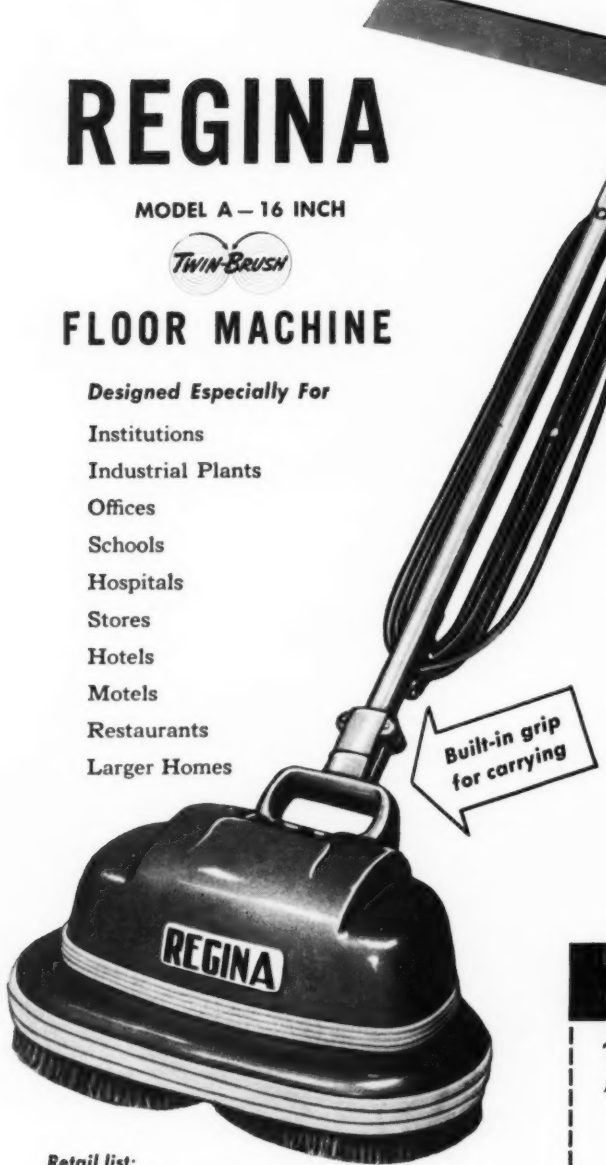

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regular mopping operation. It has to be reserved for *wax application only*.

Here Waxey demonstrates that he must first carefully wash his strand mop, and rinse it thoroughly, before he dares use it for a fresh waxing operation. He is also demonstrating another vital lesson here: that even the already clean mop must be made thoroughly damp before it is immersed in the water-wax emulsion. The reasons for this are: (1) If it is a brand new mop, it will require a little "seasoning" before it will make a good wax applicator. A short soaking in clean water will serve to "season" it somewhat. This is especially true of the cotton-strand mop. This seasoning process will serve to soak out some of the lint that is common to cotton. It will also improve its absorption qualities and thus permit it to disperse the waxing liquid better.

(2) If it is a mop which has been previously used as a wax applicator but is dry from disuse, it too will work better if it is well soaked and then squeezed dry before being immersed in the waxing fluid.

96. Be sure to get all of the surplus water out of the mop before immersing it in the wax, or this surplus water might cut the consistency of the wax. If more water is added to the wax through the over-wet mop, it will lessen the balanced consistency of the wax. This is not good!

97. Waxey reiterates that it is always good practice to wet well and squeeze dry the mop used for a wax applicator. It is very beneficial in helping to distribute the wax evenly within the applicator. It also serves a valuable purpose in helping to also distribute the wax smoothly upon the floor. It is a practice which must be developed until it becomes a habit.

98. If the container of wax has been standing for some time, it may cause the wax to separate a little. In order to obtain full benefit from the wax, it is well to agitate the container before pouring the required amount of wax into the waxing pail or pan.

99. Only enough wax need be poured into the container to provide a minimal amount of wax for the area. It is not necessary to half fill the pail or pan. Just pour in enough to coat the applicator, not soak it excessively. It must be remembered that wax, artistically and safely applied, should be only a very thin coat, or a succession of thin coats; it should never, never, be put on in gobs.

100. Waxey dips in his mop and works it around in the wax until there is a coating over most of the mop-strands. He holds it up for a moment—long enough for the excess wax to drain off—and then . . .

101. he wrings his wax-filled mop out fairly dry, leaving just enough wax on the mop with which to coat a given area. He never leaves enough wax on the mop to splash.

102. A wax-filled mop will cover quite a large area before it needs a refill. This is especially true if a large mop-applicator is being used. The reason is that only a very thin film of wax will need to be deposited on the floor. Making this thin deposit of wax-emulsion on the floor does not call for strenuous pressure for a sufficient amount of wax will be deposited by simply passing the applicator over the flooring.

Authorities differ upon the precise stroke which should be used to deposit the wax on the floor. Theories differ on whether to overlap or not to overlap. One authority may prescribe that the wax should never overlap; the lines of wax should just be touching.

Another authority will advocate that inasmuch as only a very thin film of wax is being deposited on the floor, it will not make any difference if there is overlapping. Waxey believes either school of thought is acceptable. He maintains that obtaining a smooth application is dependent on the skill of the operator. If he is a "smooth operator" he may choose either method of laying the new coat of wax.

103. The principle of traveling quite a distance with this first stroke is to bring the wax-filled mop to the most distant point of the present phase of the waxing operation. By starting at the farthest point Waxey then works back to his next area of application. He will not be trapped into one spot, which will necessitate back tracking the newly waxed area.

(Continued on Page 136)

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For this first operation, the mop may be either pushed along to its destination or dragged.

104. As he reaches the farthermost part of the area to be waxed, he turns off and meets the line of the "edging," or previous mop-border, and starts working back to the starting point.

105. Please note the pattern of Waxey's backward trek, for he walks backward during this operation. The more lightly he bears down with his mop . . . the evener the wax film will be.

If he is sufficiently skilled to overlap the last filmed area without leaving a wax ridge, he may overlap sufficiently to assure complete coverage. If he is not too skilled, he had better omit the overlapping application. It is important that wax be applied without forming ridges.

106. Once the waxer gets the "feel" of this operation, he will become familiar with the way in which the wax applicator diminishes. He will observe the application step by step and will become attuned to the moment when more wax is required.

It is the responsibility of the instructor to develop this perception so that the waxer will learn when to re-dip the applicator into the wax solution.

107. Because drying time is such a delaying feature of the waxing operation, it is frequently hurried so much that it defeats much of the purpose of waxing. No matter how long it takes, or to what extent one must go to aid in the drying processes, *drying must be allowed for and provided for before the waxer progresses to the next step of the waxing operation.*

The instructor must explain that drying time will vary and will change with the changing conditions or with the weather.

There may even be areas that will never thoroughly dry. This is true of basement areas where the flooring is in contact with the damp earth. This claminess defies the wax to dry. Such a floor can never be brought up to the desired sheen.

Another such area is one in which resilient floorings have been layed upon outdoor ramps, which join one building to another. Outdoor porches are another such area. These areas may be enclosed but the floorings continue to be damp underneath the resilient covering.

On rainy days or when there is a high degree of moisture in the air, it is difficult for the moisture in the wax to evaporate. Unless there is some other way in which the air-drying can be stimulated, it would be well to postpone the waxing operations until drying conditions are more suitable.

There are two ways to facilitate drying time. One of these is by air-movement, which can be generated by an electric fan. The other is by turning a heater unit up to its maximum. A combination of both heat and moving air is even better. If wax must be laid during poor drying days, the use of heat, or heat combined with an air movement such as can be provided by an electric fan, will have to be resorted to if desirable results are to be obtained.

It is not enough to have wax dry only in spots before the buffing and polishing operations are begun; it is of vital importance that *all of the floor be dry.* The carry-over of moist wax from the partially dry areas into the thoroughly dry areas will make for a very blotchy buffing and polishing job.

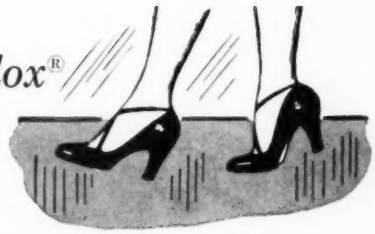
108. Waxey need not remain idle while he is waiting for the floor to dry. He can very well spend the next 20 or 30 minutes in preparing another area and laying on its wax coat, while he waits for the first area to dry. The waxing processes are slow enough without having to stand around and wait for any one area to get dry enough to buff.

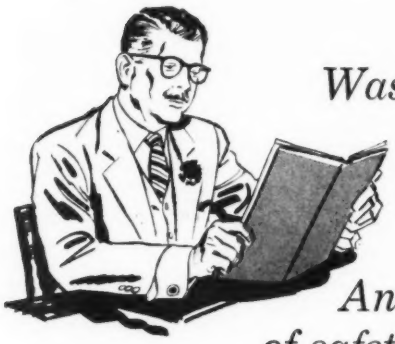
109. Here Waxey displays his ingenuity by providing air currents to facilitate drying. This is a good idea. The only occasion when it might not prove a good idea is when the outdoor air is more humid than the inside air; for instance, if it is raining or snowing, and the air is filled with moisture.

110. This method can lessen the drying time by several minutes. It is, however, a hazard to have an electric fan on any floor, especially on a hospital floor. Therefore, should it become necessary to resort to this procedure, every known safety precaution must be observed.

(Continued on Page 138)

The day Du Pont Ludox® added "anti-slip" to waxes





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111. The waxing trainee must be cautioned to place the fan at sufficient distance from the wet wax area so as to utilize the breezes to their full potential. The fan must not be too close or too far and must be frequently moved about so that it can provide moving air to all wet areas.

112. He makes a final check-up to satisfy himself that the floor is thoroughly dry; then he goes ahead.

113. Bumps, bubbles and blisters can easily occur. They may come from air being encased within the wax or from unclean undersurface, or spotty application of the wax. Whatever the reason, they must be removed before the next waxing steps are begun, else the desired end-results will not be attained.

114. The simplest way to remove air bubbles is to abrade them off the surface with friction. This can be done by setting the steel-wooler under the buffing brush, and running the buffing machine over the bumpy areas until the bubbles have smoothed out evenly with the other wax coating.

115. During the operation with the steel wooler broken bits of steel wool plus a very fine array of wax shavings are deposited on the floor. They must be removed before the next operation is begun. The vacuum sweeper is the ideal way to remove the debris. The way Waxey is sweeping it up here is not too good but it is the way that many waxers prefer.

It is now the time for the first buffing. This is only a superficial operation, but it is a necessary one. Unless this first wax film is buffed a little, the second coat of wax will not have that "satin sheen." Waxey will later explain the buffing operation.

(The manual on Waxing will be continued in the April issue of this magazine.)

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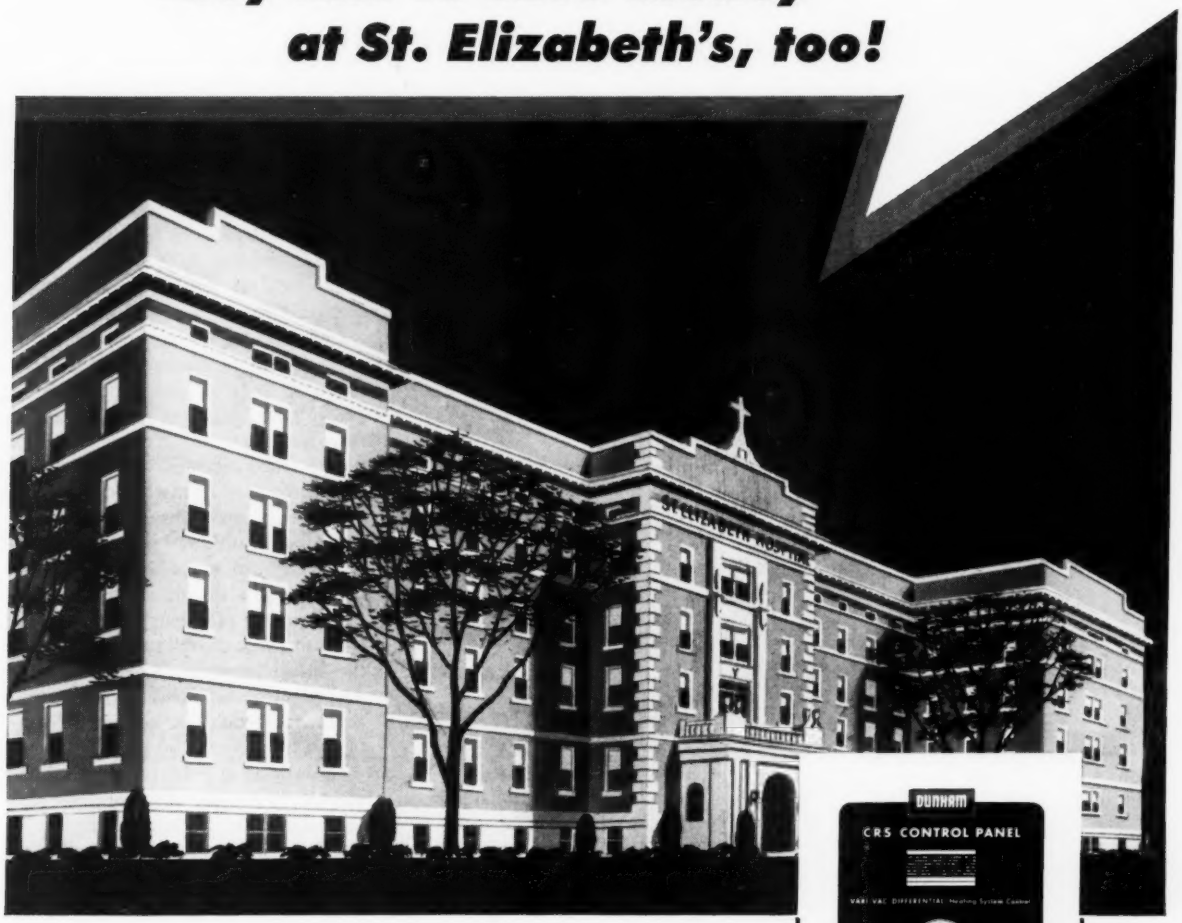

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Round Table on Insurance

(*Continued From Page* 80)

schedules, reporting forms and claim forms, in order to take care of the requirements of all the insurance companies with which we do business!

MR. JONES: Some of the financial benefits in the form of higher income from patients having some type of insurance may be offset by a considerable increase in administrative costs to process the various insurance claims.

MR. GRONER: As you know, I am a strong supporter of Blue Cross and believe that every hospital in this country should put forth a major effort to help Blue Cross increase its coverage. On the other hand, we must not overlook the fact that the thousands of policies written by commercial insurance companies have also had some real social benefit. These policies have made it possible for more and more people to get the hospital care they need.

MR. JONES: When you ask for an advance payment, do many patients tell you that because they have insurance coverage they should not have to make any advance payment?

MR. GRONER: We have just had an example of that right here in Memphis. One of the big meat packing companies with employes all over the country elected to get hospital insurance from a commercial insurance company. The president of the meat packing company, in writing to all employes, pointed out that whenever they needed hospital care they had only to present themselves to the hospital, show their insurance coverage card, and be admitted without advance payment. I immediately wrote to both the president of the insurance company and the president of the packing company, first complimenting them on the broad coverage for hospital care, and pointing out that this was a fine move and would be beneficial to the health of the employes. However, I then went on to point out that it didn't seem right for the insurance company and the meat packing company to enter into a joint agreement to supply services which had to be given by a third party, the hospital, without allowing the hospital to be in on the agreement. I explained our policy of asking for an advance payment. Obviously, the insurance company and the packing company had no right to attempt to dictate our admitting policies.

MR. JONES: This action of the insurance company and the meat packer is certainly in sharp contrast with the way Blue Cross operates. The Blue Cross does not make any agreement with its subscribers until it has entered into a full agreement with the hospital which must supply the services. Possibly the commercial insurance companies would build up more friendship among hospitals if they considered the hospital problems before they make agreements with any employer on hospital insurance coverage. Certainly the hospital has the right to be in on any agreement affecting its services or policies in rendering services.

This discussion of admission and credit problems in relation to Blue Cross and insurance will be continued next month.

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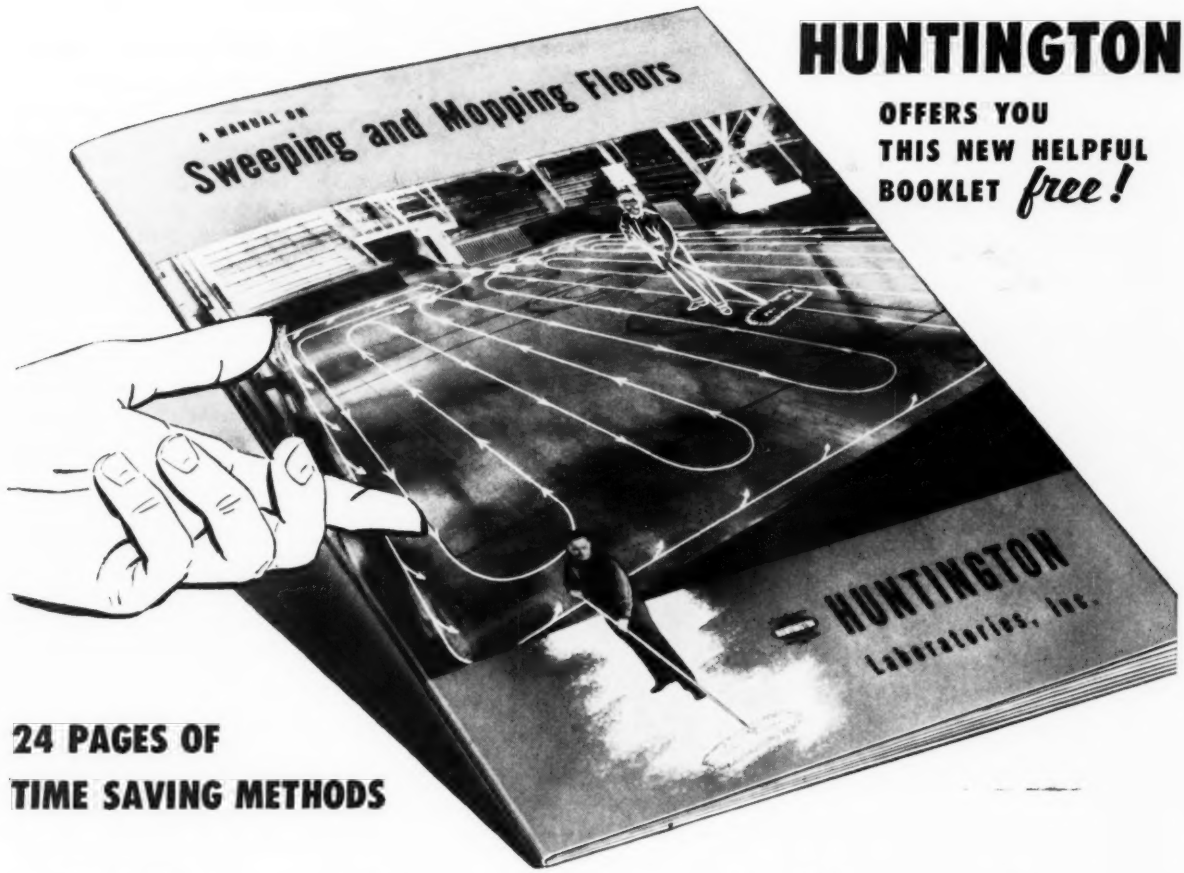

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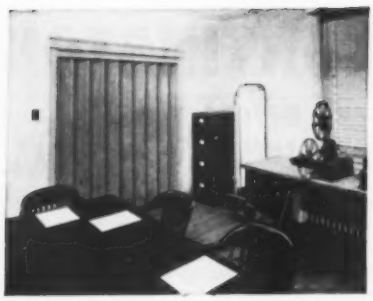

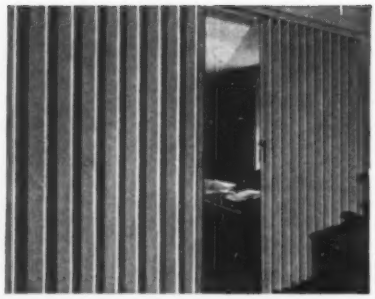

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USING EMPLOYES' TIME

(*Continued From Page* 90)

One administrator cited a turnover rate of 65 per cent per year. A department head cited 300 per cent per year for his department. In both cases, however, turnover statistics were not accumulated in a way to permit critical study. Turnover for all reasons—deaths, retirements, marriages, quits due to dissatisfaction, and so forth—were grouped as one total figure.

In order to make progress on controlling and reducing turnover, data will have to be collected in a way that will permit answers to some of the following questions and improvements when some of the answers are known:

1. What is hospital turnover rate, on a yearly, monthly, weekly basis?
2. What is the turnover rate for departments and sections on a yearly, monthly, weekly basis?
3. Are there seasonal variations?
4. Are there variations among departments and sections?
5. Among what occupations is turnover highest and lowest?
6. Among what types or groups of employes (*e.g.* age, sex, length of service) is turnover highest and lowest?
7. What are the stated reasons for turnover?
8. What other reasons for turnover may exist?
9. Which of these reasons may not be within the control of the hospital (*e.g.* deaths, retirements)?
10. Which of these reasons may be within the control of the hospital (*e.g.* discharges, layoffs, quits due to dissatisfaction)?
11. Why are employes voluntarily leaving the employ of the hospital?
12. Can reasons for turnover be reduced or minimized, or can employment be made more attractive to reduce the voluntary separations?

This list of sample questions might be redesigned or improved to meet specific needs of a given hospital or department, or might also be used with modification as an instrument in analyzing absenteeism. In a recent address at Cornell, Peter Arakelian, then personnel director of the New York University—Bellevue Medical Center, suggested that, "every absentee is a potential turnover statistic," and that absenteeism should be watched no less closely than turnover.

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Of almost equal importance were the noise and vibration factors. Site considerations made it mandatory that our laundry be situated in the basement of the building where such considerations might well affect the patients' rest and quiet. The silent chain drive of Hoffman flatwork ironer and the advanced engineering of the extractor offered the ideal solution of these nuisances.

With the ever increasing resistance of the public to rising hospital costs, economy of operation was a prime consideration. Hoffman demonstrated its awareness of the need for such economy, through their engineering assistance in laying out the most efficient machinery setup to meet our particular laundry requirements. This is reflected in our ability to operate our laundry with less personnel than the average hospital of comparable size in the area. The fast-drying action of the Greyhound tumbler, pinpoint control of supplies used, and greater life of linens, due to the easy unloading of the washers, all spell economy of operation.

Twenty-four hours a day, three hundred and sixty-five days a year, the hospital must minister to the needs of its sick and injured. Dependability is the keyword! The experience of these institutions which we visited, with properly installed equipment and maintenance-free operation over long periods of time, and the comforting knowledge of parts and service at a moment's notice (as demonstrated by Hoffman's record throughout World War II) qualified Hoffman as absolutely dependable.

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*An actual letter in our files. Name on request.

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NEWS DIGEST

Protestant Groups Set Record Attendance . . . Rep. Bolton Releases Figures on Nursing Shortage . . . Health Foundation Makes Study of Medical Costs . . . A.C.H.A. Marks 21st Anniversary . . . A.H.A. Holds Mid-Year Meeting

American Protestant Hospital Association Meeting Sets Record With Attendance of More Than 1000

CHICAGO.—A record attendance of more than 1000 set the stage for successful meetings of the Protestant hospital groups here in February. The programs of the individual denominational groups and of the over-all American Protestant Hospital Association provided a nice balance between the importance of a Christian atmosphere in the hospital and the practical problem of restricting charity care to the amount a given hospital can afford.

Donald Cordes, administrator of the Iowa Methodist Hospital in Des Moines, addressing the opening meeting of the hospital section of the National Association of Methodist Homes and Hospitals, urged that a policy governing free services be worked out, adopted by the hospital board of trustees and made available in writing to all concerned. He said, "There is no such thing as free hospital care, and we must be careful to take free or part-pay patients only to the extent that we have funds (other than those derived from charges to full-pay private patients) available to pay for every single day of free care."

METHODIST OFFICERS: Left to right: J. M. Crews, president; Karl Meister, executive secretary; Harold P. Barnes, past president.

DON'T TAX PAY PATIENTS

"Private patients," said Mr. Cordes, "should not be taxed to pay for indigent care. Paying for indigent patients in our hospitals is the responsibility of the entire community." Mr. Cordes urged that discounts be given only where real financial need can be proved, and never given purely as a courtesy gesture.

Donald Bloom, controller of Wesley Memorial Hospital in Chicago, advocated a definite dollar amount in the budget for free service. "A hospital must not jeopardize its financial stability by giving free care to indigent patients beyond its ability to finance it," said Mr. Bloom.

The Methodist group heard Leonard A. Scheele, surgeon general of the Public Health Service, discuss "The Broadening Fields of Service." Dr. Scheele emphasized the fast growing need for chronic and geriatric hospital facilities.

James M. Crews, administrator of the Methodist Hospital in Memphis, Tenn., is the new president of the Methodist hospitals and homes association. He succeeds the Rev. Harold R. Barnes of Oakland, Calif.

The Thursday morning session of the Southwide Baptist Hospital Association was urged by Dr. Frank Tripp, administrator, Southern Baptist Hospital of New Orleans, to work out a plan to exchange ideas among Baptist hospitals so that all administrators in the group would have the benefit of the best work done in all hospitals. A lively discussion of this proposition resulted in approval by the group of a one-year experimental program in the use of an executive secretary. Dr. Tripp was elected without salary to fill this post. The group voted to assess each hospital $0.50 a bed to produce the necessary funds to support Dr. Tripp in his work. It is thought that this new activity will result in a much closer relationship between Baptist churches and hospitals, and that because of this the churches will take a more active part in providing financial assistance to the hospitals and in the recruiting of student nurses and other technical personnel for hospital work.

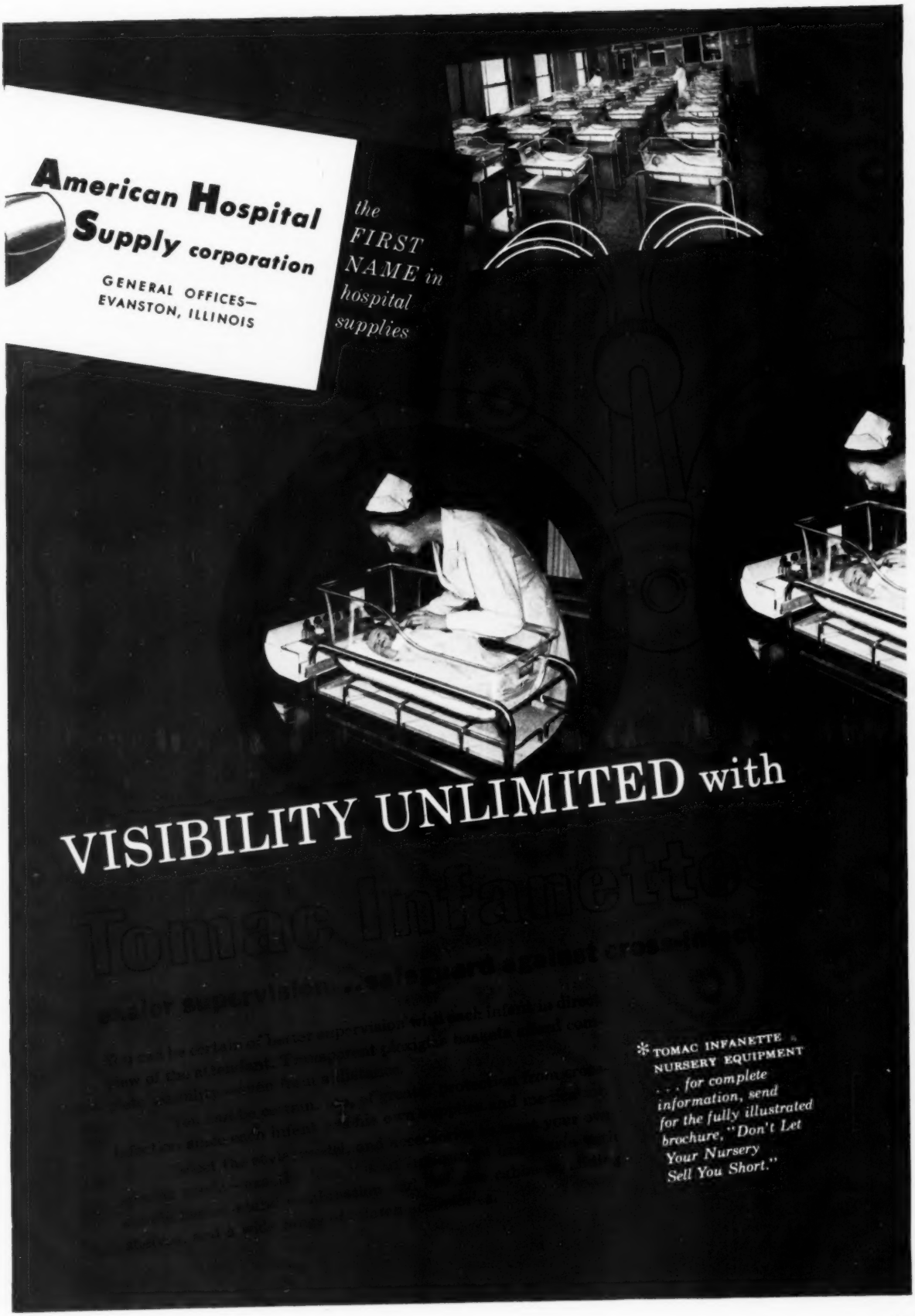
Boone Powell, administrator, Baylor University Hospital in Dallas, told the Baptist group that good public relations cannot be attained until proper employe relations are achieved. Mr. Powell pointed out that proper orientation and training of employes and the instilling of a true Christian atmosphere in the minds of all hospital employes will result in good public relations.

ABSENTEE ADMINISTRATOR

John Dudley, a past president of the American Protestant Hospital Association and administrator of Memorial Hospital, Houston, Tex., discussed problems arising in a hospital when the administrator is absent a great deal to participate in state and national hospital organizations. He also urged that every administrator have adequate, able assistants to carry on the important administrative functions in the hospital when the administrator must be absent.

The Southwide Baptists paid particular attention to the religious work which must be tied in to the practical everyday operation of a church related hospital. Like the Methodist hospital

SOUTHWIDE BAPTIST OFFICERS: Standing, left to right: Robert Murphy, Harold Prather and Wilson Turner. Seated, left to right: Clyde Sibley, Robert Guy and Frank Tripp.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NEWS...

group, the Baptists also gave due attention to the problem of courtesy discounts, particularly to denominational pastors, and urged that such discounts be given only on the basis of financial need.

In his paper on problems connected with the construction and organization of a new religious hospital in a community, DeWitt Brown, administrator, Corbin Municipal Hospital, Corbin, Ky., warned against overstaffing a new hospital, and pointed out the severe financial problems created by overstaffing when the hospital is first opened. "In selecting employes for your new hospital," said Mr. Brown, "be careful of the floaters who have been discharged from other hospitals and who are always on hand trying to get a job when a new hospital is opened." Mr. Brown urged that before the new hospital is opened the constitution and by-laws and rules and regulations of the medical staff be carefully worked out and that the governing board of the hospital and the administrator insist on the staff's being organized to meet the standards of the Joint Commission on Accreditation of Hospitals.

Harold Prather, administrator, East Tennessee Baptist Hospital in Knoxville, was succeeded as president of the Southwide Baptist Hospital Association by Wilson Turner, administrator, Baptist Hospital, Alexandria, La. Other officers elected were: president-elect, Clyde Sibley, administrator, Baptist Hospital, Birmingham, Ala.; vice president, Robert J. Guy, administrator, Baton Rouge General Hospital, Baton Rouge, La., and secretary, Robert Murphy, administrator, Mid-State Baptist Hospital, Nashville, Tenn.

CHAPLAINS' SECTION OF THE SOUTHWIDE BAPTISTS: Left to right: E. A. Verderay, Atlanta, Ga., Fred L. Bell, Nashville, Tenn., and J. F. Queen, Little Rock, Ark.

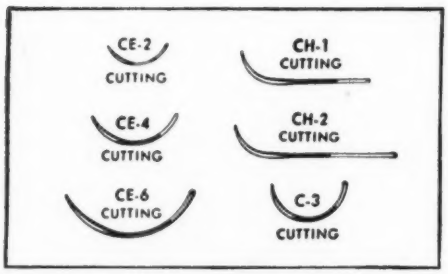
The chaplains section of the Southwide Baptist group elected the following officers: president, Fred L. Bell, Baptist Hospital of Nashville, Tenn.; vice president, E. A. Verderay, Georgia Baptist Hospital, Atlanta; and secretary, J. F. Queen, Arkansas Baptist Hospital, Little Rock.

Joseph Norby, a past president of the American Hospital Association, and formerly administrator of the Columbia Hospital in Milwaukee, told the Lutheran Hospital group that the board of trustees is the supreme authority in the hospital. He urged administrators to keep members of the board thoroughly informed of both the business and professional practices in the hospital but not to get into the habit of running to the board of trustees for all decisions. "Seek the advice of members of your board of trustees on major problems," said Mr. Norby, "but don't become so dependent upon the board that you are unable to make many of your own decisions."

Paul Hanson, administrator, Emanuel Hospital in Portland, Ore., succeeded Dr. Albert Seidel of the Walther Memorial Hospital in Chicago as president of the Lutheran Hospital Association.

(*Continued on Page* 148)

OFFICERS AND TRUSTEES OF THE A.P.H.A. Left to right: L. B. Benson, St. Paul; Arden Hardgrove, Louisville, Ky.; Lee S. Lanpher, Cleveland; John Belinsky, Newton Center, Mass.; C. E. Copeland, St. Louis; Carl Rasche, St. Louis; Frank Prentzel, Philadelphia, and Albert G. Hahn, Evansville, Ind.



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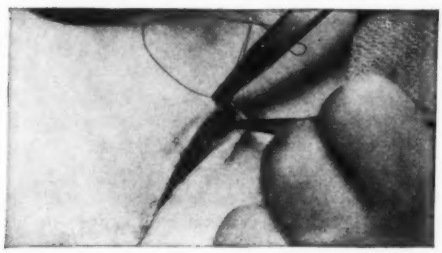

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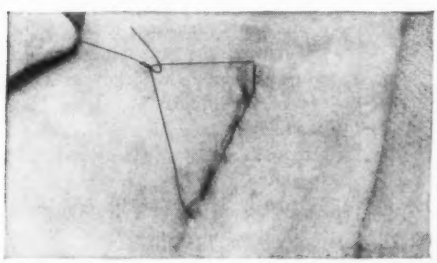

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NEWS...

Discussion at the meeting of the Episcopal Hospital Assembly was largely devoted to religious work in the hospital. The luncheon meeting of this group heard a talk by Dr. John Hinman, assistant to the director of the Joint Committee on Accreditation of Hospitals, on the work done by the Joint Commission to date. Dr. Hinman urged the Episcopal group to have its attending medical staffs so organized that regular medical audits will be carried out. "Such medical audits," said Dr. Hinman, "will greatly improve the standards of medical care in any hospital."

Rev. Edward Turner, member of the board of trustees of the Parkview Hospital of Pueblo, Colo., turned the office of president of the E.H.A. over to Karl H. York, administrator of St. Luke's Hospital in Racine, Wis. Rev. Fred A. Springborn, chaplain of Norton Infirmary, Louisville, Ky., was made president-elect. Treasurer of the Episcopal group will be Mrs. Calista B. Fulkerson, administrator of All-Saints Hospital in Philadelphia. Rev. F. Radall Williams, chaplain of the Toledo Hospital, Toledo, Ohio, was elected secretary.

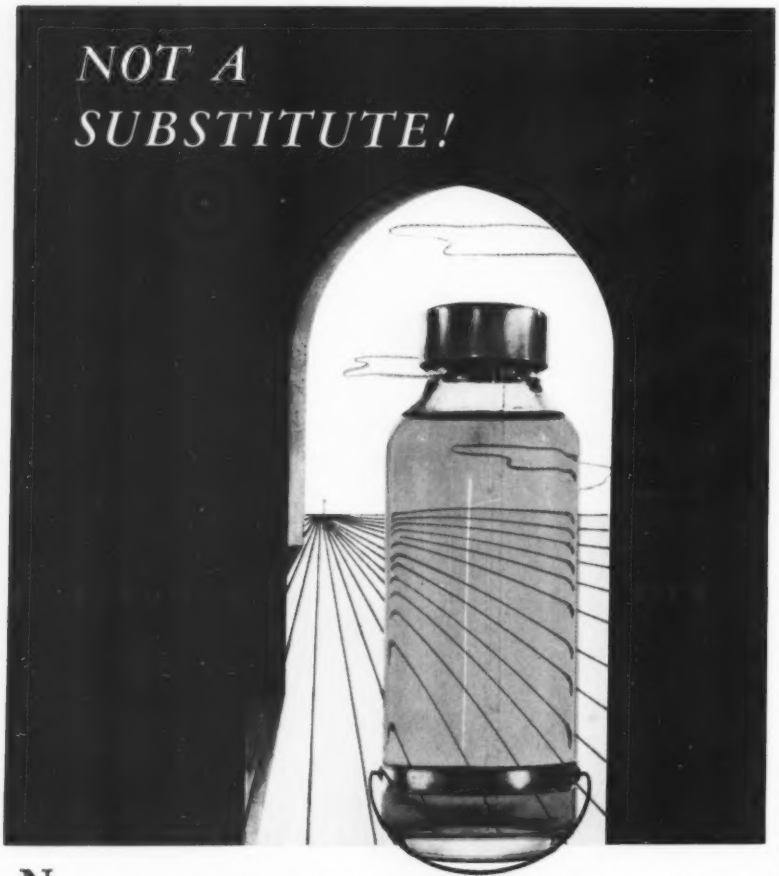
Chaplains Lloyd E. Beebe, Albany, N. Y., left, and Jack Greenawalt, Pittsburgh.

Meeting concurrently with other denominational groups were the members of the Commission on Benevolent Institutions of the Evangelical Reformed Church, the Association of Mennonite Hospitals and Homes, and the Salvation Army.

All denominational groups joined in the banquet of the American Protestant Hospital Association on Thursday evening, February 11. John Nuveen, president of the Chicago Sunday Evening Club, was the featured banquet speaker.

Ritz E. Heerman, general manager of the Lutheran Hospital group of California and president of the American Hospital Association, urged all church related hospitals to come up with answers to President Eisenhower's proposal to extend voluntary medical care to more persons. "The President has given us notice to come up with some solutions in the health field within our voluntary framework. I hope we will not let our opportunity to save the voluntary way go by default," Mr. Heerman said. "President Eisenhower's plan for hospital care is one of moderation," Mr. Heerman continued. "Who can quarrel with his statement that no man should be denied access to proper health care because of where he lives, the money he makes, his color or his creed? To disavow this would be to disavow the teachings of Christ."

The meeting of the American Protestant Hospital Association on Friday morning, February 12, featured a half hour devotional service led by Rev. Carl C. Rasche, administrator of the



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Loss of zeolite was stopped cold the day we introduced the "Double Check" water softener. This ingenious design truly "locks in" the zeolite. Prevention of zeolite loss during back-washing is an important feature that has become increasingly more important, *but* . . .

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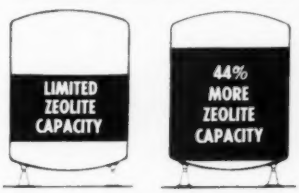

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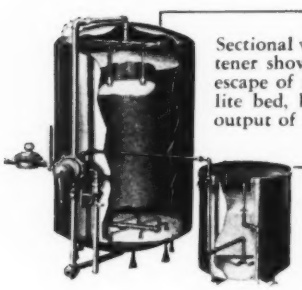

Sectional view of "Double-Check" Softener showing design which prevents escape of zeolite; permits deeper zeolite bed, better regeneration, greater output of soft water.

The "Double-Check" can be built into your present softener. If your existing softener is in fairly good condition you can have the advantages of zeolite loss prevention and extra capacity at surprisingly moderate cost. This type of modernization, along with our high capacity zeolite, has stepped up soft water output three to ten times in hundreds of cases.

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NEWS...

Evangelical Deaconess Hospital of St. Louis. The service was followed by the session devoted to the subject, "A Christian Atmosphere in the Church Related Hospital—How to Get It." Dr. Alfred D. Biggs, member of the medical staff of St. Luke's Hospital in Chicago, said that if the medical staff organization does not discipline staff members who do not live up to the highest standards of professional and moral values, the trustees must act. "Hospital administrators," said Dr. Biggs, "must set a Christian example by word and deed if a Christian spirit is to prevail throughout the hospital." Dr. Biggs urged all except the smallest hospitals to provide full-time or part-time chaplain service.

Sister Hilda Muensterman, director of nurses, Evangelical Deaconess Hospital, St. Louis, stressed the need for schools of nursing to make every effort to assist the growth of the student spiritually as well as mentally. She said that head nurses of all nursing units and the nursing unit secretaries should know about the religious needs of patients, and that the work of student nurses should be related to the patient's religious needs.

Dr. Frank Tripp of New Orleans pointed out that "The Christian spirit of employes in any hospital takes its roots in the basic philosophy of the top organization of the hospital. Members of the board of trustees and the hospital administrator must transmit a Christian philosophy to everyone working in the hospital."

Rev. C. E. Copeland, administrator of the Baptist Hospital of St. Louis, succeeded Lee S. Lanpher, administrator, Lutheran Hospital of Cleveland, as president of the American Protestant Hospital Association. Other officers are: president-elect, Rev. Carl C. Rasche, administrator, Evangelical Deaconess Hospital, St. Louis; first vice president, Rev. Frank Prentzel Jr., administrator, Methodist Hospital, Philadelphia; second vice president, Hal G. Perrin, administrator, Bishop Clarkson Memorial Hospital, Omaha, Neb.; secretary, Rev. L. B. Benson, administrator, Bethesda Hospital, St. Paul. Trustees elected are: Arden Hardgrove, Norton Memorial Infirmary, Louisville, Ky.; Rev. John Belinsky (representing the chaplains); Lee S. Lanpher; Brig. Paul Seiler, Salvation Army; H. L. Dobbs, administrator, Baptist Hospital, Louisville, Ky.; H. Ernest Bennett, Mennonite Hospital Association. Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, Ind., is executive secretary of the association.

Meeting in separate sessions, the chaplains' group of the American Protestant Hospital Association elected Rev. Jack Greenawalt of the Pittsburgh Medical Center as president to succeed Chaplain Lloyd E. Beebe, of the Albany Federation of Churches, Albany, N.Y.

Martland Center Dedicated

NEW YORK.—Lt. Gen. Leslie R. Groves, former head of the Manhattan Project, gave the principal address at the dedication ceremonies of the Martland Medical Center at Newark, N.J., recently. After paying tribute to Dr. Harrison S. Martland for his work in discovering the effects of radiation, he discussed the development of atomic energy in its peace-time applications and radioisotopes as instruments for research in diagnosis and treatment.

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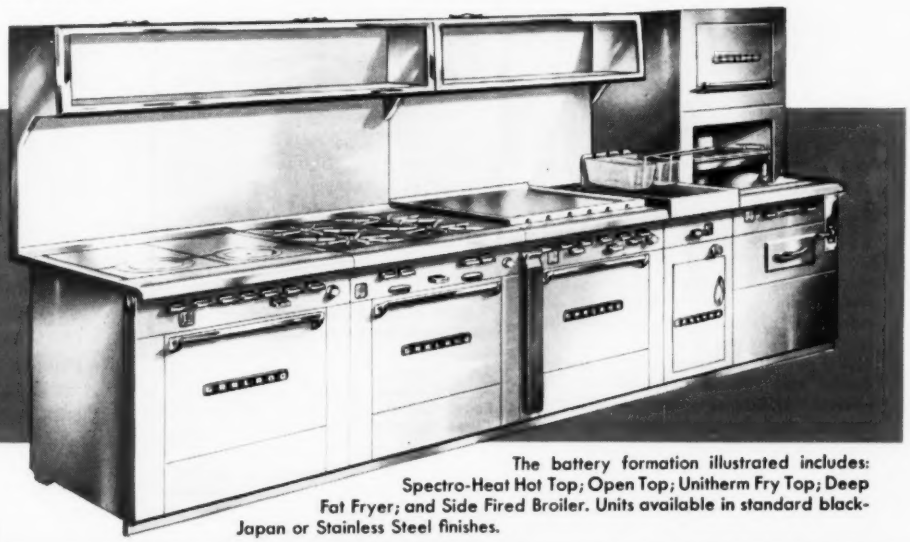

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NEWS...

Gundersen Endorses Accreditation Commission at Annual A.H.A. Mid-Year Conference

CHICAGO. — Physicians in private practice have everything to gain and nothing to lose from the operation of the Joint Commission on Accreditation of Hospitals, Dr. Gunnar Gundersen, chairman of the executive committee of the board of trustees of the American Medical Association, told presidents and secretaries of state and regional hospital associations attending the annual mid-year conference of the American Hospital Association here last month.

Final evaluation of the accreditation program must be made on the basis of its contribution to the care and welfare of hospital patients, Dr. Gundersen stated. Membership on the staff of an accredited hospital is a precious asset to the practicing physician, he said. Discipline and upgrading of staff standards must be accomplished through the hospital staff organization itself, rather than through the county medical society, as a few doctors have proposed, he concluded.

In another presentation on accreditation, Dr. Robert S. Myers, administrative assistant of the American College of Surgeons, and Dr. Jose Gonzalez, hospital inspector on the staff of the American Hospital Association, presented a lively demonstration of right and wrong attitudes and procedures on the part of hospital administrators in simulated interviews between an administrator and an inspector for the Joint Commission.

Reporting the first year's activity of the Joint Commission, Dr. Edwin L. Crosby, commission director, said 1301 inspections of hospitals had been conducted. These inspections resulted in 949 full approvals and 204 provisional approvals, Dr. Crosby stated.

Speaking on accreditation from the point of view of the hospital administrator, Stuart K. Hummel of Milwaukee said that acceptance of accreditation standards by the board of trustees of a hospital gives the administrator a "clear directive" to lead medical staff officers and committees into an effort to meet the standards. Reports from the commission following an inspection and explaining standards help the conscientious administrator to discharge his primary responsibility of providing leadership in maintaining staff standards, Mr. Hummel stated.

Thomas Langdon, administrator of the Hahnemann Hospital of San Francisco, suggested that the Joint Commission should hold regional conferences throughout the country for the enlightenment of doctors, hospital trustees and administrators and the public as to the nature and meaning of the accreditation program. There are still some doctors, including officers of county medical societies, who have the feeling that the Joint Commission is a "conspiracy of hospital administrators" to persecute staff members, Mr. Langdon reported. He suggested the regional conferences as a means of combating this point of view.

Hospital association officials attending the conference, on a show of hands, indicated that the "hospital-specialist" problem has quieted down during the

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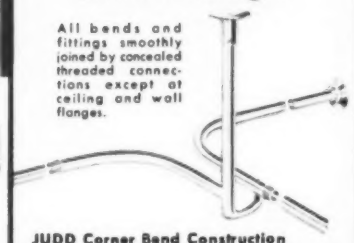

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Judd white or pastel curtains in Sanforized Jean cloth, Twill or Fiberglas (flame- and mildew-proof; no ironing; launder and hang). Rust-proof grommets in top hem.

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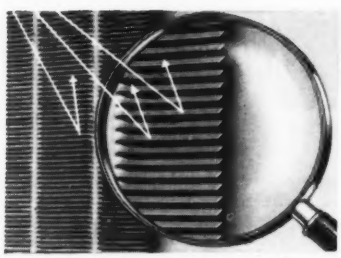
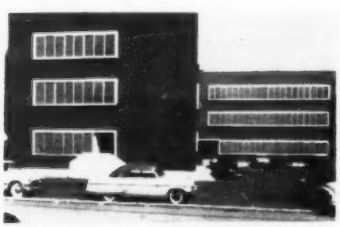


Magnified view shows patented construction of Kaiser Aluminum Shade Screening.



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NEWS...

last year. Remaining problems are concerned more frequently with the relationship between hospitals and anesthesiologists than with other specialists, the group indicated.

For the first time, the mid-year conference was divided into workshop discussion groups. Separate groups considered problems in planning and conducting institute programs, insurance, Blue Cross-hospital relations, programs for small hospitals, trustee problems, indigent care legislation, press relations, and district hospital conferences. The discussion groups listed problems in each of these fields and reported suggested solutions and programs to the conference.

A.M.A. Congress Warned of Deficiencies in Training of Foreign Physicians

CHICAGO.—Hospitals were warned against the acceptance of interns and residents trained in foreign medical schools in an address presented here last month by Dr. Willard C. Rappleye, dean of the faculty of medicine at Columbia University.

Speaking at the 50th Annual Congress on Medical Education and Licensure of the American Medical Association, Dr. Rappleye said the acceptance of foreign trained interns and residents was lowering the quality of medical care available to American hospital patients. Furthermore, he added, the problem was increasing in magnitude all the time. "About one in four of all interns and residents in our hospitals are aliens," he declared. "The foreign interns have doubled in the last three years; alien residents have increased more than 300 per cent in the same period."

The infiltration of foreign physicians into American hospitals is creating two classes of citizens in terms of medical care, Dr. Rappleye charged. "Those of the first class will be attended by graduates of approved medical schools; those of the second class will receive medical care largely from graduates of unrecognized medical schools," he stated. "Unless this situation is met with courage and the conviction that we shall not surrender the results of 40 years of effort in raising the standards of medical licensure, practice and education in this country, we shall be faced with condi-

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NEWS...

tions resembling those of 50 years ago and with the prospect in 20 to 25 years of having to go through another reformation in medical education and licensure."

Dr. Rappleye recommended that smaller hospitals should provide supervised educational experience for medical graduates, and that hospitals which "cannot provide satisfactory training and guidance of the house staff" should seek some other method of discharging their responsibilities to patients, such as employment of properly trained physicians on a salary basis. He also recommended more careful screening of foreign medical school graduates by means of practical examinations.

CALLS CREDENTIALS DOUBTFUL

In another address dealing with the problem of foreign trained doctors, Dr. Stiles D. Ezell of Albany, N.Y., said that war and upheaval in most foreign countries during the last generation had deteriorated the quality of medical school training in many foreign countries. At the same time, Dr. Ezell stated, these conditions stimulated the emigration of foreign medical graduates to the United States. Credentials presented here by doctors trained in many foreign countries are worthless, he said. Records of medical training in many instances have been destroyed, and the reliability of credentials offered is often questionable. A number of foreign medical schools became "diploma mills" during and after World War II, he said.

"It is an unusual reflection on the residency training programs in this country that large numbers of foreign graduates have completed this specialized training without any consideration of the deficiencies in their basic medical training or their eligibility for licensure," Dr. Ezell said. "It would appear that this time could be better spent in providing them with a proper medical background before they undertake specialist training."

Dr. Edward L. Turner, secretary of the Council on Medical Education and Hospitals, recommended a uniform plan for screening the professional competence of foreign trained doctors for American hospital appointments. "Some mutually acceptable screening device would furnish far more information regarding basic knowledge and

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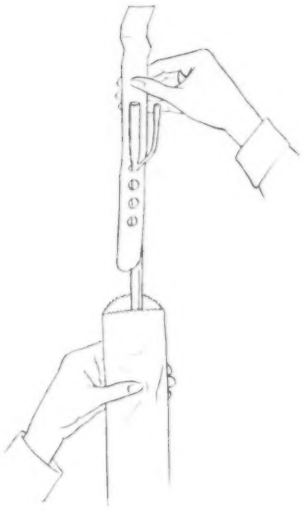

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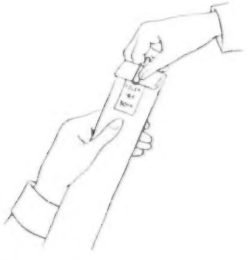

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competence of graduates than can be obtained through a program of listing foreign medical schools on the basis of presently available means of evaluation," Dr. Turner stated. "The basic needs for medical knowledge and competence can be no different in Maine than they are in California, Minnesota or Florida," he added.

In another report to the congress, Frank G. Dickinson, director of the association's bureau of medical economic research, said the distribution of physicians in the United States, in relation to the population they serve, in "extraordinarily good."

In 757 areas studied, Dr. Dickinson reported, only 75 had more than 2000 persons per active physician, and these areas were among the most sparsely populated in the nation, Dr. Dickinson said.

The range of physician-population to 5100 persons in Monticello, Utah, to one physician to 380 persons in Rochester, Minn., it was reported.

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Rep. Bolton Releases Survey of Health Care Situation in America

WASHINGTON, D.C.—Congresswoman Frances P. Bolton (R.-Ohio), last month reported results of a nationwide survey aimed at revealing all the facts about the shortage of nurses, both registered and practical, to supply the nation's over-all needs. Unless something can be done immediately to reverse this trend, Mrs. Bolton declared, "Our country will face a truly appalling crisis in health care."

The survey included 10,000 questionnaires to a representative list of nurses, doctors, hospital administrators, nursing schools, educators, laymen, state governors, federal and state health authorities, Mrs. Bolton reported.

Questions had to do with the nurse shortage and its causes; whether financial aid was needed and if so where; what they felt about federal aid, state aid, or a combination of both.

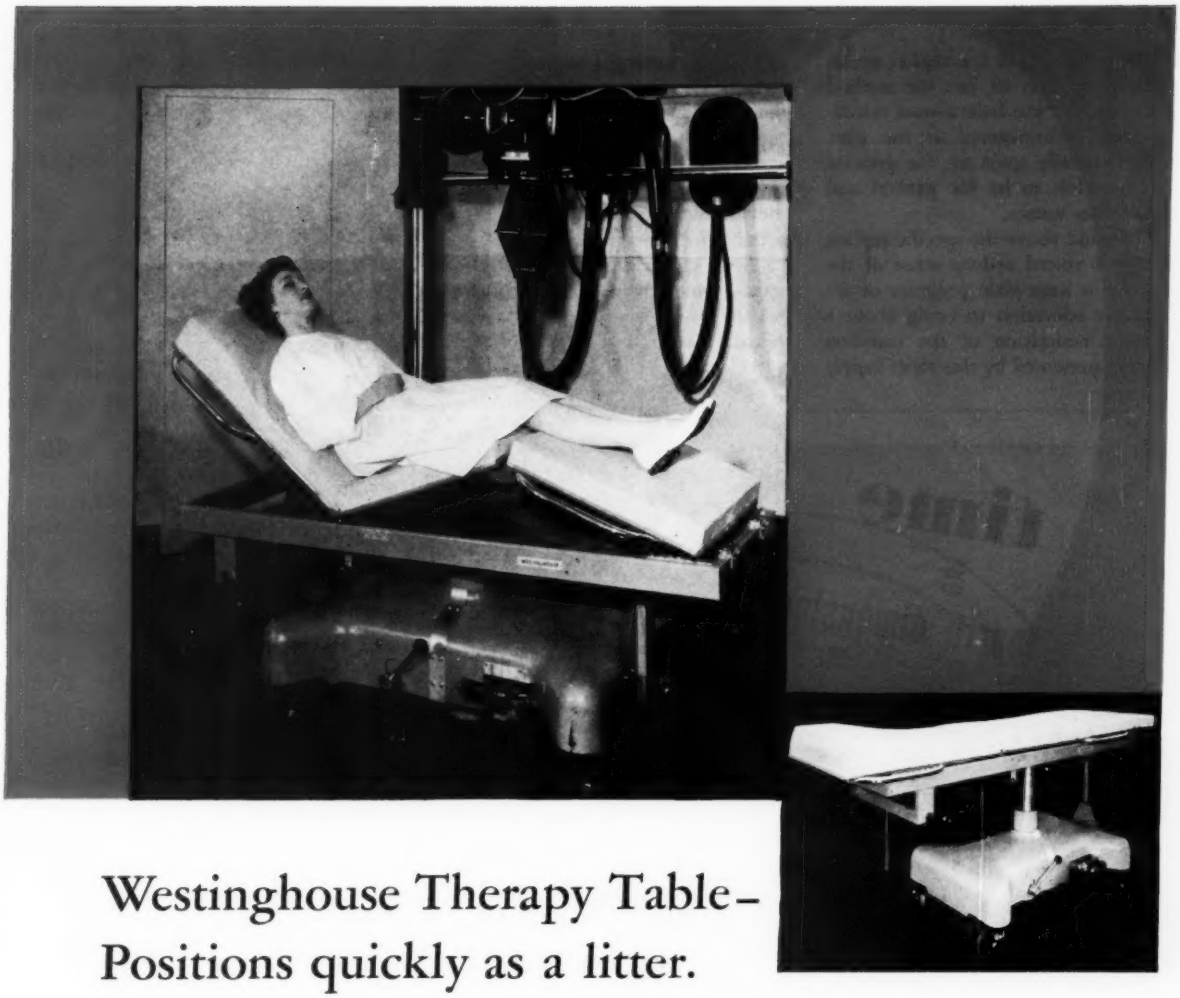
"The response was amazing both in volume and in the high caliber of thoughtful approach to so confused and many-faceted a problem," Mrs. Bolton reported. "Nearly 4000 replies were received—almost a 40 per cent response. The results seem to indicate an urgent need for remedial action, and indicate lines of approach which can guide us in finding the road to ultimate solution for this very major need to safeguard the nation's health."

There was overwhelming accord that there is indeed a nursing shortage, it was indicated. Many opinions were given as to the different causes: financial, psychological, social. The difficulties attendant on obtaining sufficient new recruits to take nurse training were particularly emphasized as were low pay, long and irregular hours. Competition from other fields, and within the nursing field itself, was emphasized.

"Many replies spoke of the seeming decline in altruism which expresses itself in the reluctance of many young women today to consider the rôle of 'ministering angel' an adequate reward for low wages," the report said.

"Strong urging of financial aid carried with it in many replies the warning that money of itself would not solve the problem, though it would greatly help.

(*Continued on Page* 160)



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"There were some few replies which wanted no aid at all, but the method most approved was federal-state matching funds administered at the state level. Generally speaking, the greatest need was felt to be for general and private duty nurses.

"Over and above the specific replies, there was voiced a deep sense of the need for a large-scale program of informative education to bring about a dramatic realization of the common problem presented by this short supply of trained nursing personnel. Today, as the survey dramatically brings out—there are misunderstandings, misconceptions, antagonisms and areas of disagreement between the various groups involved which must be lessened in the mutual interest of all dedicated to serving the nation's health.

"Such a program of education must stem from extended factual research which would supplement this survey of attitudes and opinions. As one respondent said, 'There is needed an objective study covering different types and sizes of institutions, different size communities and different geographical areas.' Many recommended that federal funds be used for such research."

Health Foundation Releases Results of Medical Cost Study

NEW YORK.—The Health Information Foundation last month announced results of a comprehensive survey of medical costs.

Findings were made public by Kenneth Williamson, formerly executive vice president of the Foundation, now director of the Washington Service Bureau of the American Hospital Association.

The survey provides a comprehensive national picture of medical costs, and throws new light on many aspects of health insurance protection about which only fragmentary or inconclusive facts have been available.

The Foundation's reports deal with: (1) the number of people protected by voluntary health insurance, parts of the population not protected, and other aspects of participation; (2) cost incurred by families for hospital, surgical, and other medical services, and the extent to which health insurance is helping to meet such costs; (3) the effects of health insurance upon the utilization of hospital, surgical and other medical services; (4) the extent to which families are in debt owing to medical expenses.

The survey facts are based on person-to-person interviews in homes, conducted last June and July for Health Information Foundation by the National Opinion Research Center of the University of Chicago, documenting the medical expenses of 8846 individuals during the previous 12 months.

Some of the important findings documented in the text and tables of the four summaries are:

The Extent of Voluntary Health Insurance

A total of 58 per cent of the population, or 89,500,000 people, now have some type of health insurance. This represents a growth of 83,900,000 in the last 15 years, compared with a total of 5,600,000 people who were protected in 1939.

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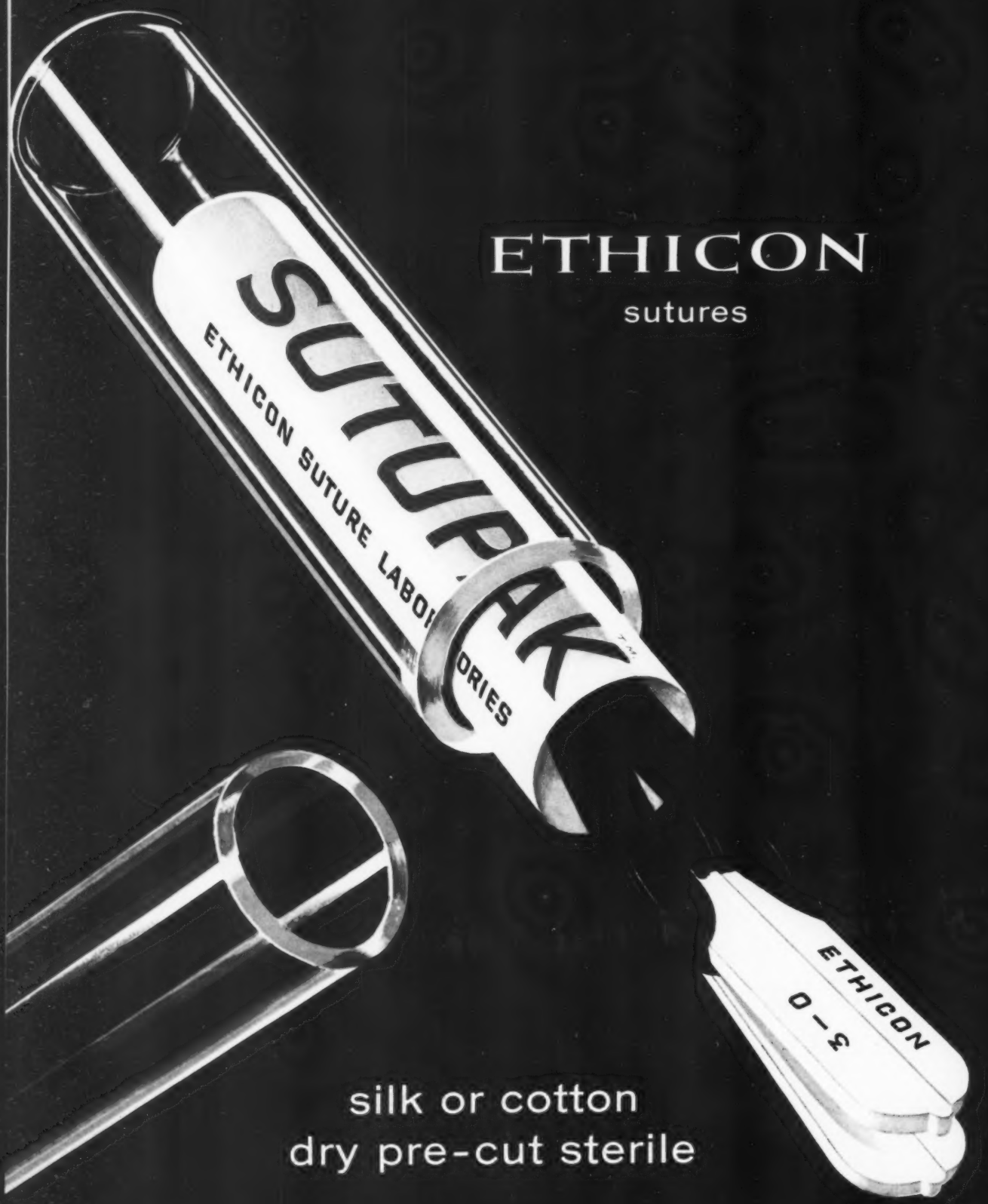

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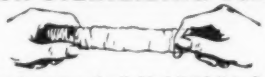

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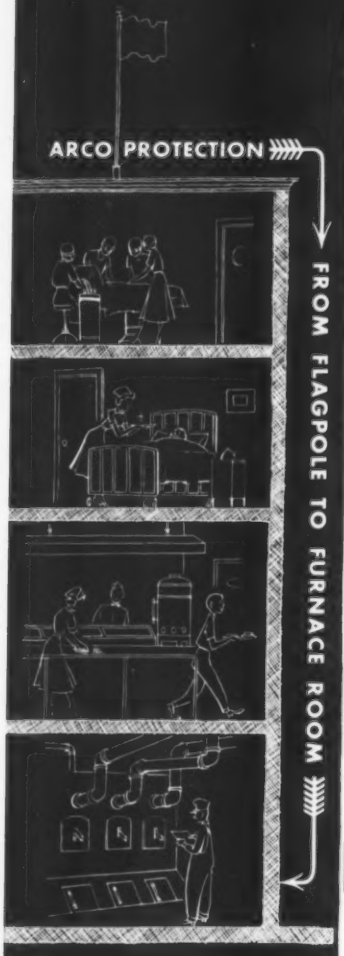

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How many families have some health insurance protection, by income group, is revealed as follows: In families with incomes under $3000, 41 per cent of all families in the nation have some coverage (within this group are many aged, widows, and indigents). In the $3000 to $5000 income bracket, 71 per cent of the families have some coverage. In the $5000 and over group 80 per cent have some coverage.

Among the 89,500,000 families with some type of health insurance, 80 per cent, or 71,600,000 families, obtained their policies through their place of work or through some other group.

Costs of Medical Care, Related to Health Insurance

A total of $10,200,000,000 cost was incurred from July 1952 through June 1953 by families for medical and dental services and goods. President Eisenhower's message gave an estimate for this figure of more than $9,000,000,000. Of the total gross cost, $1,500,000,000 was covered by insurance benefits.

Fifty per cent of the total gross costs incurred by all people in the nation for hospital expenses, or $1,000,000,000, were covered by insurance benefits, although only 57 per cent of the population have insurance.

Thirteen per cent of the total physician costs, or $500,000,000, were covered by insurance benefits. Within these costs, 38 per cent of the surgical fees to physicians were paid by insurance benefits.

The average cost per family for medical and dental services during the year covered, for all 50,000,000 families with and without insurance in the U.S., was $205. Among 28,000,000 families with hospital insurance, 59 per cent, or 16,520,000, had more than 80 per cent of their hospital expenses covered.

Among the 24,000,000 families having surgical or medical insurance, 45 per cent, or 11,000,000, had 80 per cent or more of their surgical expenses covered; but only 10 per cent had some benefits toward other medical costs.

Emphasis in the President's message to Congress regarding hardships suf-

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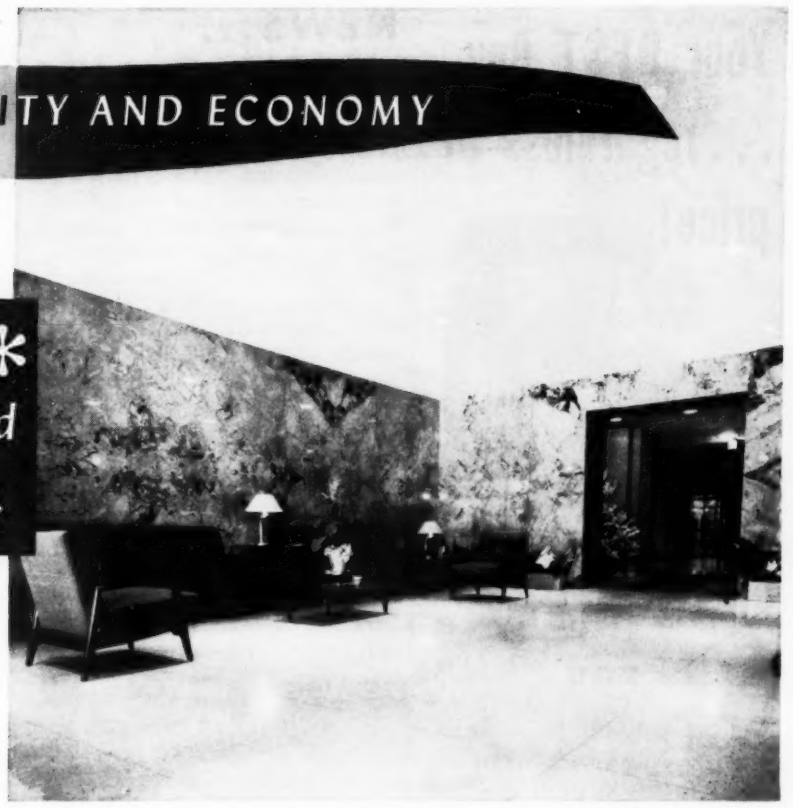

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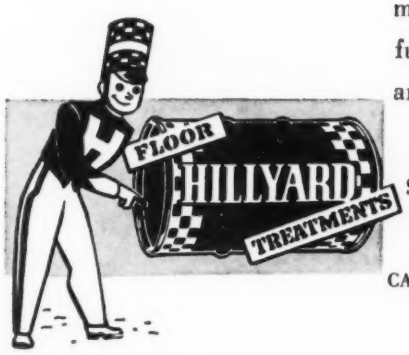

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City..... Zone... State.....

NEWS...

fered by families with heavy medical expenses is underscored in the survey's findings by the following figures: 6,000,000 families last year had medical expenses totaling 10 to 19 per cent of their income. Two and one-half million families had medical expenses totaling 20 to 49 per cent of their income. One million families had medical expenses totaling 50 to 100 per cent or *more* of their income, and approximately 500,000 families fell within the latter category. These figures represent a total of 7 per cent, or 3,500,000 of the nation's families whose medical expenses for the year totaled from 20 per cent to 100 per cent of their income, or more.

Utilization of Health Insurance

The admission rate for hospital care for people with insurance was 13 per 100, and for those without insurance, 10 per 100. This underscores the fact that people with insurance utilize hospital services more than those without insurance. Not until the income level of families reaches $7500 or more, the survey reveals, is the hospital admission rate equal for those with some insurance and those without insurance.

The comparative degree to which urban and rural populations with insurance utilize hospital services is revealed in these figures: Urban populations with insurance show a hospital admission rate of 12 per 100 people. Rural nonfarm populations show a rate of 14 per 100. Rural farm areas show a rate of 17 per 100.

In data revealing the amount of surgery undergone by people with and without insurance, the rate is 7 surgical procedures per 100 persons in families with insurance, and 4 per 100 in families without insurance.

Figures reporting dental services reveal that 34 per cent of the people see a dentist in a year, and that dental care is obtained pretty much in ratio to income. In families with less than $2000 income, 17 per cent of the persons see a dentist in a year. The percentage increases by income level until it reaches 56 per cent for persons in families with incomes of $7500 or more.

Debt Among Families Owing to Medical Expenses

Eight million families, or 16 per cent of all families in the nation, had medical debts as of July 1953 totaling

THE

FLEET ENEMA

DISPOSABLE UNIT

- **As a routine enema**
- **To relieve fecal or barium impactions**
- **For preoperative cleansing and postoperative use**
- **For proctoscopy and sigmoidoscopy**
- **For use in collecting stool specimens**

In ready-to-use polyethylene "squeeze bottle"...sanitary rectal tube sealed in cellophane envelope...distinctive rubber diaphragm prevents leakage and controls rate of flow. Each single use unit of 4½ fl. ozs. contains in each 100 cc., 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate — an enema solution of *Phospho-Soda* (Fleet), as effective as the usual enema of one or two pints . . . provides complete left colon catharsis in two to five minutes.

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EASY *to administer with one hand*

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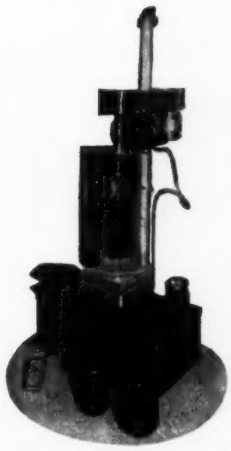
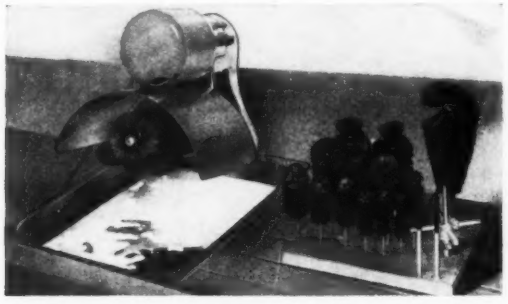
OVER 2,000 INSTALLATIONS OF SPARKLING GLASSWARE

Southern Cross Brush Washers eliminate inefficient, time-consuming soaking and hand washing methods forever; eliminate breakage. The perfect friction action of nylon bristles cleans every surface instantly and removes completely any type of glass film or heavy soil. Whatever your glass cleaning problem, there's a Southern Cross Glass Washer to solve it quickly, efficiently, economically.

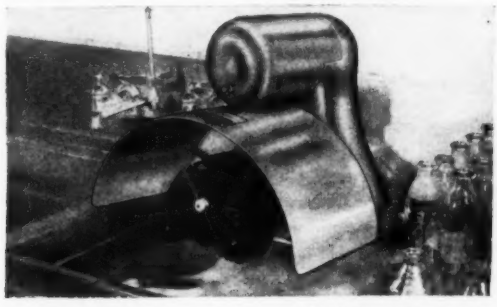


MODEL 800-A . . . For all large bottles of from 2 liters to 5 gallon capacity such as gastro evacuator, serum or solution.

A MODEL FOR EVERY PURPOSE

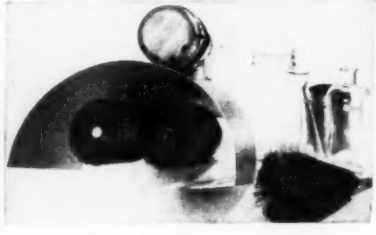


MODEL 300-B . . . The standard for laboratory glassware—from 10-mm tubes to 1-liter erlemeyer flasks. Cleans 2 pieces at once, inside and out. Portable, with complete range of interchangeable standard laboratory brushes.

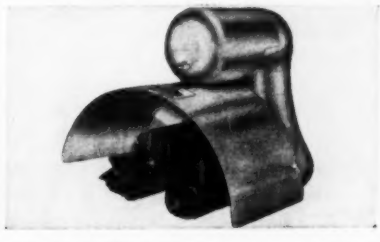


MODEL 300-C . . . Used in over 1600 formula rooms for cleaning 4- and 8-oz. narrow-neck or wide-neck nursing bottles. Saves time, eliminates breakage, insures absolute cleanliness.

MODEL 300-E . . . Washes test tubes, syringes. Ideal for central supply room handling up to 900 pcs. per hour. Needs no plumbing or special fixtures.



MODEL 100-C . . . For your large glassware from 1 liter to 4 liters capacity, yet completely portable. Ensures maximum cleanliness at minimum cost.



MODEL 300-A . . . Washes drinking glasses. Over 6,000 installed in commercial kitchens. Cleans 2,000 glasses per hour, utilizing 1 operator to wash, rinse, sanitize. Portable; needs no special plumbing or fixtures.

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NEWS...

$1,100,000,000. Of this amount, families owe financial institutions and individuals $200,000,000. This means that a total of $900,000,000 is owed by families directly to hospitals, doctors, dentists and for other medical services.

Commenting on the significance of the survey figures released, Mr. Williamson said: "The study underlines President Eisenhower's statement that private and nonprofit health insurance organizations should be encouraged to offer broader health protection to more families. The problem is to find a mechanism through which health needs can be met. Voluntary health insurance, as shown in this study, has demonstrated without question its possibilities to go still further as a means for financing the health needs of the American people."

Methods Improvement Discussed by Speakers at Milwaukee Institute

By ROBERT M. JONES
Administrator, Waukesha Memorial Hospital
Waukesha, Wis.

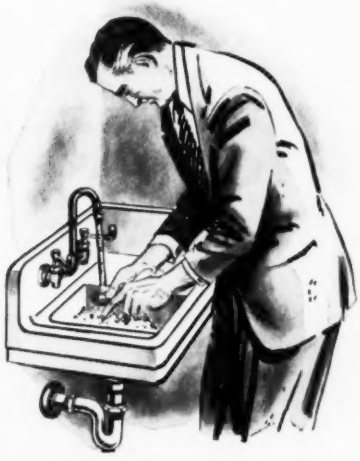
MILWAUKEE.—The third in a series of special institutes, arranged in conjunction with Milwaukee industries, was held in Milwaukee on January 13, with a total registration of 113. The institute, dealing with methods improvements, was planned and conducted with the assistance of the Milwaukee chapter of the Society for Advancement of Management, by Franklin D. Carr, program chairman of the Wisconsin Hospital Association.

The keynote address, delivered by Prof. Marvin E. Mundel, associate director of the Marquette University Management Center, defined methods engineering as the determination of the preferable way of doing work. Administration often thinks methods engineering is only used to find the cheapest way of doing the work but this is not the case, Prof. Mundel said. The preferable way depends on the criteria used; it may be the most economical way, the way that gives the most service, or the way that requires the least physical effort.

The speaker stated that a systematic technic to find the preferable way is far better than a haphazard method; he briefly outlined the steps to be used as follows: (1) state in specific terms the objective sought; (2) break job down into specific parts concerning

In hospital rooms . . . doctors' offices . . . small rooms

new AMERICAN-Standard lavatory puts corner space to practical use



■ The new American-Standard corner lavatory (HF 12203 LA shown) meets small space requirements with complete convenience features. It is only 26 x 20 inches in size . . . can put wasted corner space to practical use.

Designed for convenience in use, this compact fixture offers a handy integral drainboard and bowl and six-inch high splash back to protect walls. Genuine vitreous china construction assures complete sanitation — it is non-absorbent, easy to care for, won't become permanently stained. Wrist control faucet handles permit washing without hands touching fitting. Gooseneck spout has Spring-Flo aerator to prevent splashing. All fittings are bright, non-tarnishing Chromard.

For flexibility of installation, the new American-Standard corner lavatory is available with drainboard on either left or right side. Your architect or plumbing contractor can give you full details.

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which information is available; (3) select applicable material; (4) assemble a solution; (5) use the evaluating material to check suitability of solution in relation to the objective; (6) make a trial run; (7) apply, if it works on trial.

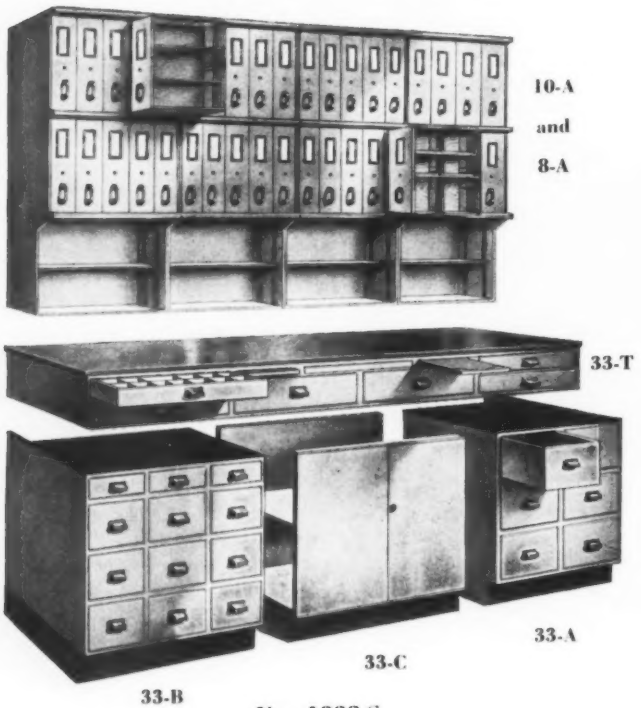
Next, Walter J. Jagalowski, manager of methods and standards for the Chain Belt Company, discussed various methods of collecting facts and briefly outlined the use of flow charts and various symbols in common use today. He also pointed out that after a solution has been reached it must still be sold to both management and the worker. This job can be made much easier if the worker assists in arriving at the solution.

Following Mr. Jagalowski's talk the group was divided into five workshops dealing with dietary, central stores, office, housekeeping and laundry, and nursing service, each led by a member of the S.A.M. In these sessions, hypothetical problems were proposed and each group worked out a solution following the technic outlined by Dr. Mundel and Mr. Jagalowski.

At luncheon, John H. Smith, general manager of General Electric X-Ray Corporation, talked on "The Value of Methods Engineering As I See It." He pointed out that hospitals, as well as industry, face competition with public demand today and methods engineering is one way to meet that competition. If we don't meet it, the next step will be governmental medicine, said Mr. Smith. He also pointed out that we must give the public the best possible hospital care at the lowest possible cost. Finally, Mr. Smith asserted, the proportion of civilian workers to the population is decreasing each year and, therefore, if we are to continue or raise our present standard of living, the productivity of each worker must be increased.

The last speaker of the day was D. E. Cox, chief industrial engineer, Tracksson Company, who summed up the topic. He pointed out that, in dealing with employes, we must consider the individual and not the group. His final point was a most important one and that was that methods engineering does not necessarily mean that we must purchase new equipment or spend money on plant changes. Properly done, it may mean only changing work methods while using the same equipment.

IS YOUR Rx DEPARTMENT EFFICIENT?



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is as important to your hospital as is your operating room, or any of your other physical equipment. For an efficient prescription department our Engineering Department will plan, layout and arrange your pharmacy without obligation.

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Alabama Association Names New Officers

MOBILE, ALA.—Arthur L. Bailey, administrator of Jefferson and Hillman Hospitals, Birmingham, Ala., was named president-elect of the Alabama Hospital Association at its annual meeting here in January, succeeding Katherine White-Spunner, administrator, Mobile Infirmary.

Douglas Goode, administrator of Jackson Hospital, Montgomery, was named vice president, and John L. Howell, administrator, Carraway Methodist Hospital, Birmingham, is the new treasurer. Harry Gauntt, administrator of Sylacauga Hospital, Sylacauga, was elected to the board of trustees.

The annual meeting was attended by more than 200 hospital administrators, pharmacists, members of the women's auxiliary and hospital trustees. The association adopted amendments to its constitution providing for the employment of an executive director.

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only LUDMAN Auto-lok WINDOWS give performance like this!

HERE ARE JUST A FEW OF THE MANY HOSPITALS EQUIPPED WITH LUDMAN WINDOWS . . .

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Buffalo, New York
St. Agnes Hospital
Fond du Lac, Wisconsin
Hospital Dormitory Building,
State Training School
Clinton, South Carolina
Good Samaritan Hospital
Dayton, Ohio
St. Francis Hospital Addition
Burlington, Iowa
Easley Hospital
Easley, South Carolina
St. Joseph's Hospital
Eureka, California
Community Memorial Hospital
South Hill, Virginia
Health Center
Monroe, Georgia
Morris County Welfare Home
Morris County, New Jersey
Southwestern Samaritan Hospital
Kalamazoo, Michigan
Valdosta Hospital
Valdosta, Georgia
Wyoming County Community Hospital
Warsaw, New York
Washington County Hospital
Chatham, Alabama
State TB Hospital
Salem, Oregon
Hancock Memorial Hospital
Britt, Iowa
Toledo Health Center
Toledo, Ohio
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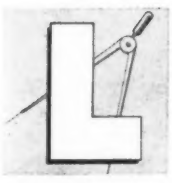

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  It's a *concentrate*. Comes in a tiny bottle. May be placed out of sight or out of way.
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NEWS...

Massachusetts Association Elects Dr. Guy W. Brugler

BOSTON. — The Massachusetts Hospital Association at its meeting here in January set an attendance record with 747 delegates turning out.

As its president-elect the association named Dr. Guy W. Brugler, administrator, Children's Medical Center, Boston. Abbie E. Dunks, director, Boston Dispensary, succeeded to the presidency, and Georgie M. Boulter, administrator of New England Baptist Hospital, Boston, became treasurer.

MASSACHUSETTS OFFICERS: Left to right: Abbie E. Dunks, Dr. Guy W. Brugler, and Georgie M. Boulter, all of Boston.

Newly elected trustees are: Dr. Philip D. Bonnet, administrator, Massachusetts Memorial Hospitals, Boston; Richard T. Viguers, administrator, New England Center Hospital, Boston; John W. Cavers, superintendent, Wesson Memorial Hospital, Springfield, and Dr. Myrtle B. Crudim, administrator, Clinton Hospital, Clinton.

Two Hospitals Report Successful Fund Drives

EAST LIVERPOOL, OHIO.—Fund raisers for the expansion project of East Liverpool City Hospital here exceeded their $750,000 goal by $269,251, to bring results of the drive to $1,019,251.

With the oversubscription at East Liverpool, the campaign chairman said that "many things pared from the original plans now can be restored, assuring even better facilities for our care and the care of our friends."

Within a few days of City Hospital's announcement early in February, came word from the Memorial Hospital Building Fund Workers of Johnstown, Pa., who reported they had raised $430,879 more than the $1,300,000 required.

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CANCER is the cruelest enemy of all. No other disease brings so much suffering to Americans of all ages.

YET—though 23 million living Americans will die of cancer, at present rates—there is reason for hope. Thousands are being cured, who once would have been hopeless cases. Thousands more can have their suffering eased, their lives prolonged. And every day, we come closer to the final goal of cancer research: a sure and certain *cure* for all cancer.

THESE THINGS have all been helped by *your* donations to the American Cancer Society. *This* year, please be especially generous!

Cancer
MAN'S CRUELEST ENEMY
Strike back—Give
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A COMPLETE LINE OF

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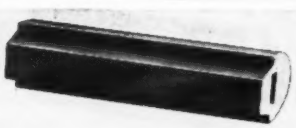

These new angle, doughnut and strip type bumpers are made in a distinctive, non-marking neutral green color. They have high resiliency and a very tough abrasive quality. Walls, door facings and furniture will not be marred and beaten when you use these easily installed Darnell Rubber Bumpers.

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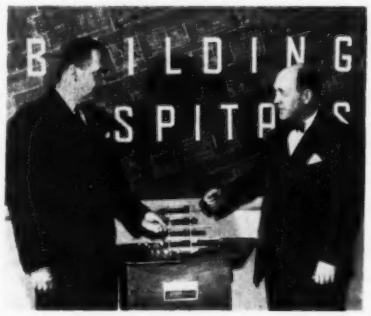
NEWS...

Exhibit Shows How H-B Hospitals Are Planned

WASHINGTON, D.C. — An exhibit showing how hospitals have been planned and built to meet public needs under the Hill-Burton program was opened here last month in the Department of Health, Education and Welfare.



Surgeon-General Scheele, left, and Dr. John Cronin inspect the Hill-Burton exhibit.

The exhibit is in the elevator lobby on the fifth floor of the Federal Security Building, where the department's offices are located.

In plans, photomurals, models and legends, the exhibit shows how the Hill-Burton program operates, from the time the individual hospital project is first conceived, through planning and building stages to its actual operation providing services for the community.

Washington Alumni Officers

ST. LOUIS.—Linn B. Perkins, assistant administrator of Christ Hospital, Cincinnati, was elected president of the Alumni Association of the Washington University Department of Hospital Administration at its annual election of officers in December. He succeeded Fred P. Ryder, manager of Cincinnati Sanatorium, Cincinnati.

Hugh R. Vickerstaff, assistant manager, Veterans Administration Hospital, Houston, Tex., was named president-elect. Other new officers are: vice president, Donald R. Bergstedt, assistant director, Oakwood Hospital, Dearborn, Mich.; secretary, Warren W. Simonds, associate director, David P. Whol Jr. Memorial Hospital, St. Louis; treasurer, Lloyd Jenson, superintendent, Children's Mercy Hospital, Omaha, Neb.

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  Not the normal substitution of stronger, less obnoxious odor for the weaker one.
- ***new economy!***
  Costs far less. 1/10 as much goes twice as far as standard deodorants.
- ***a new discovery!***
  A non-toxic compound created especially for hospitals—for patient's rooms, wards, nurseries, lavatories, work rooms, surgeries and kitchens.

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NEWS...

COMING EVENTS

AMERICAN ACADEMY OF GENERAL PRACTICE, Public Auditorium, Cleveland, March 22-25

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN ASSOCIATION OF NURSING HOMES, Annual Convention, Seelbach Hotel, Louisville, Ky., Oct. 18-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Chicago, Sept. 11-13. ***Institutes for Hospital Administrators:*** 6th Midwest Institute, Colorado Woman's College, Denver, June 14-18; 6th New York Institute, Columbia University, New York City, June 21-July 2; 6th Western Institute, Stanford University, Palo Alto, Calif., Aug. 2-13; 22d Chicago Institute University of Chicago, Aug. 31-Sept. 10; 5th Chicago Advanced Institute, University of Chicago, Sept. 6-10; 9th Southern Institute, Richmond, Va., Oct.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 13-16.

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 21 to 25.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Regional Meetings: Stoneleigh Hotel, Dallas, Tex., March 26, 27; President Hotel, Kansas City, Mo., April 5, 6. Annual Meeting: Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

AMERICAN SURGICAL TRADE ASSOCIATION, Grand Hotel, Mackinac Island, Mich., June 7-9.

ASSOCIATION OF WESTERN HOSPITALS, Hotel Statler, Los Angeles, April 26-29.

CALIFORNIA HOSPITAL ASSOCIATION, Fresno Hacienda, Fresno, Oct. 28, 29.

CALIFORNIA SOCIETY OF X-RAY TECHNICIANS, 16th Annual Educational Convention, Hotel Sainte Claire, San Jose. April 29, 30.

CANADIAN NURSES' ASSOCIATION, 27th Biennial Meeting, Banff Springs Hotel, Banff, Alta., June 7-11.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Va., April 29, 30.

CATHOLIC HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, N.J., May 17-20.

CONFERENCE OF CATHOLIC SCHOOLS OF NURSING, Atlantic City, N.J., May 15, 16.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 2, 3.

INDIANA HOSPITAL ASSOCIATION, Institute on Legal Aspects of Hospital Administration, Student Union and Food Service Building, Indiana University Medical Center, Indianapolis, April 8, 9; Student Union Building, Indiana University Medical Center, Indianapolis, June 10, 11.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

KANSAS HOSPITAL ASSOCIATION, Wichita, Nov. 12, 13.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Seelbach, Louisville, April 20-22.

LOUISIANA HOSPITAL ASSOCIATION, Baton Rouge, April 29, 30.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 8, 9.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 26-28.

MIDWEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo. April 28-30.

MISSISSIPPI HOSPITAL ASSOCIATION, 23d Annual Convention, Hotel Heidelberg, Jackson, Oct. 13-15.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Biennial Congress, Drake Hotel, Chicago, June 2-5.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 29-April 1.

NEW YORK STATE DIETETIC ASSOCIATION, Albany, April 29, 30.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 29-April 1.

SOUTHEASTERN ASSEMBLY OF NURSE ANESTHETISTS, Atlanta, Ga., April 7-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 3-5.

UPPER MIDWEST HOSPITAL ASSEMBLY, Hotels Lowry and St. Paul, St. Paul, May 12-14.

VETERANS ADMINISTRATION INSTITUTE IN PSYCHIATRY AND NEUROLOGY, V.A. Hospital, Lyons, N.J., April 21.

WISCONSIN HOSPITAL ASSOCIATION, Milwaukee, March 18.

S.F. Hospital Conference Reelects Officers

SAN FRANCISCO.—William B. Hall, administrator of University of California Hospitals in San Francisco, has been elected president of the San Francisco Hospital Conference for a second term.

Also reelected were: vice president, E. O. Massman, administrator of French Hospital, and treasurer, Sister Mary Philippa, administrator of St. Mary's Hospital.

In his inaugural remarks Mr. Hall said:

"San Francisco is one of the outstanding medical centers of the nation, an eminence it owes in large part to its two great medical schools. This is a challenge to its hospitals which I am happy to say the hospitals meet.

"Although hospital costs have risen in line with everything else, modern medical and hospital technics are making the stay of patients in hospitals shorter, returning them to their homes and employment sooner.

"As more of our citizens obtain the protection of hospital insurance, the impact of hospital charges will be felt less and less. One of the aims of our hospitals will be to encourage more of this third-party protection."

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NEWS...

Survey of Nursing Functions Released by California State Nurses' Association

SAN FRANCISCO. — Approximately 60 per cent of the professional nurse's time is devoted to direct patient care, and the remaining 40 per cent is spent in administrative, clerical and domestic duties, according to a study of nursing functions conducted by Louis J. Kroeger and Associates for the California State Nurses' Association.

A summary of the report by Mr. Kroeger was released here last month in the *Bulletin* of the association. The study was conducted in 41 California hospitals over a period of three years, Mr. Kroeger said.

The study revealed a range of 439 separate duties performed by nursing personnel, it was reported. The largest number, 374, listed duties actually performed by one or more professional nurses in the hospitals studied. Supervisors performed 288 duties, and auxiliary personnel performed 272 of the listed tasks.

"The casual reader of the data may conclude that 40 per cent of a nurse's time is wasted because it is not devoted to direct patient care," Mr. Kroeger stated. "Those who understand nursing service will realize that a certain part of these nonpatient-care duties are necessary supporting activities to direct patient care, and we all know that circumstances vary considerably depending on the size of the institution and the time of day when duties are observed.

"Obviously, for example, in a small institution on the night shift, it would be ridiculous to say that more than one person should be engaged in a unit if that one person can render all necessary direct patient care and still have enough time to do all other necessary related work on the same shift."

Variations between nursing duties in government and nongovernment hospitals showed up in the study, Mr. Kroeger reported. For example, the higher percentage of time spent in medications, treatments and procedures was in the government hospitals, while a higher percentage on "special service duties" occurred in nongovernment institutions, the report indicated. Clerical duties bulked up larger in government hospitals, but nurses in nongovernment hospitals spend more time on housekeeping and messenger duties.

Interpretation and analysis of the data, which comprise 1000 pages of text and tables, may provide a basis on which to redefine nursing responsibilities in relation to the medical profession, Mr. Kroeger suggested. "Our check list of nursing duties includes a great many highly specialized procedures, yet we have found a relatively small part of the total number of nurses or of the total amount of nursing time being devoted to these specialized procedures," he stated. "To the extent these procedures may intrude into the field of medical practice, the discovery that any of them is being carried on will, of course, call for some revision in the concept of the distinction between the nurse and the doctor. On the other hand, the extent to which specialized procedures for which nurses are prepared are not being regularly performed suggests that the medical practitioner may want to begin to re-

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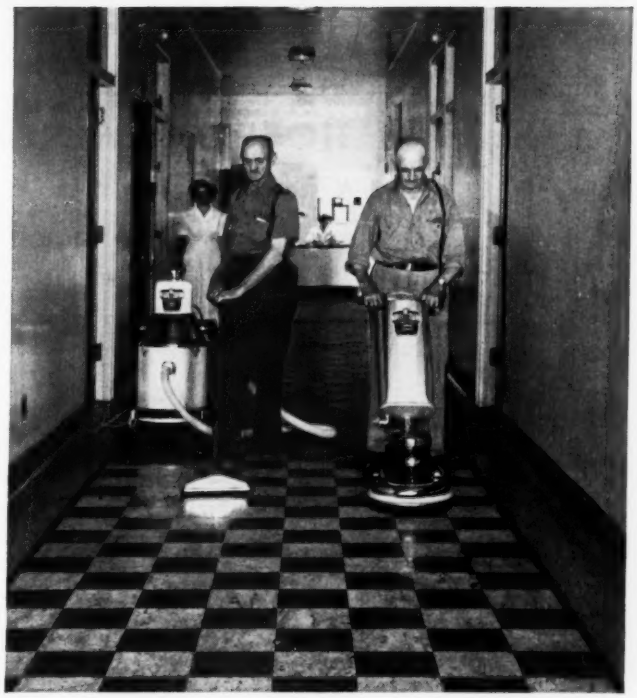

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vise his practices in order to utilize more fully the nurse's special skill.

"By the same token, the data will show hospital administrators many ways in which they might be able to reform their organization and staffing patterns in order to utilize preparation more fully."

Presenting a preliminary report to the house of delegates of the California State Nurses' Association last November, as reported in the *Bulletin*, Mr. Kroeger quoted from the concluding chapter of Volume 1 of his report, as follows:

"Nursing is a profession. Its members are educated for professional service. To the extent they are unnecessarily used in nonprofessional work, their talent and education are wasted. To the extent they are prepared for tasks they never perform, their preparation is unnecessarily prolonged and complicated. To the extent they are called upon to do work of another profession, they may be required to violate law, policy and recognized professional practice. To the extent they are burdened with supervisory and administrative responsibility without corresponding title and salary, they are imposed upon."

In addition to his own staff, Mr. Kroeger reported, the study required the services of a volunteer committee of specialists in many aspects of nursing and nursing research.

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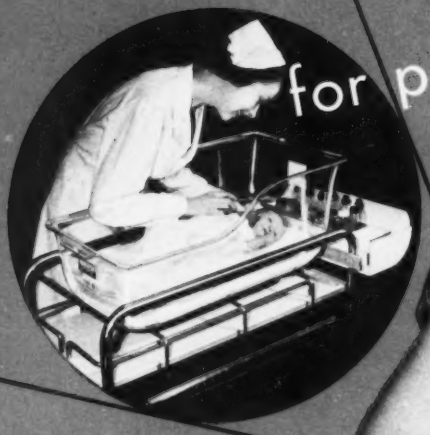
A.C.H.A. Celebrates Twenty-First Year

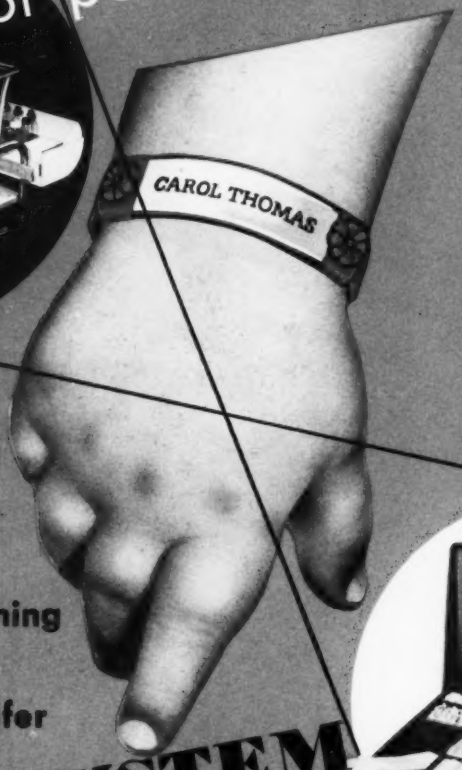
CHICAGO. — The American College of Hospital Administrators recently celebrated its twenty-first birthday with a dinner for the board of regents at the Palmer House. President Merrill F. Steele, M.D., superintendent of Christ Hospital, Cincinnati, cut the birthday cake. Organized in 1933 with 18 members, the group now numbers 2500 covering the United States and Canada. A history of the organization by Ira A. Kipnis of the University of Chicago will be published in the fall, in time for the twentieth annual meeting in Chicago.

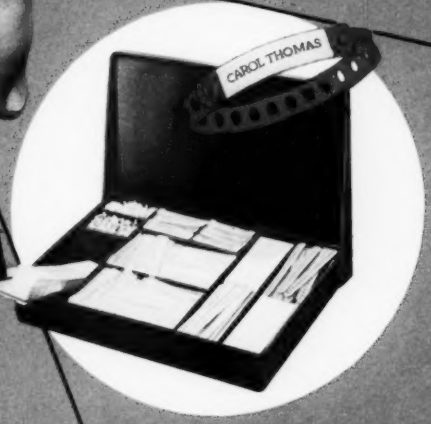
Cutting the A.C.H.A.'s birthday cake, left to right, J. Dewey Lutes, Dr. Merrill F. Steele, Dean Conley, executive director.

Other officers besides Dr. Steele include: Dr. C. A. Kerlikowske, director of University Hospital, Ann Arbor, Mich., president-elect; Dr. Fraser D. Mooney, director of Buffalo General Hospital, Buffalo, N.Y., immediate past president; J. Dewey Lutes, administrator of Woonsocket Hospital, Woonsocket, R.I, first vice president; Cecile Tracy Spry, administrator of General Hospital, Everett, Wash., second vice president.

for positive identification







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Requires Little or No Attention. A Carrier produces ice automatically—just set it and forget it. It virtually cleans itself—unique self-cleaning action flushes out the entire system automatically after every ice harvest. And its simple operation with few moving parts reduces maintenance to a happy minimum.

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NEWS...

Sherlock, Smith and Adams Win Prize for Plan of U.M.W. Hospital

BOSTON. — The architectural firm of Sherlock, Smith and Adams of Montgomery, Ala., and Tallahassee, Fla., in a competition conducted by *Progressive Architecture* for plans of structures in progress rather than completed buildings, won the top design award in the health category for the proposed Whitesburg Memorial Hospital at Whitesburg, Ky. This structure is to serve beneficiaries of the United Mine Workers Welfare and Retirement Fund and will be a supply terminal for other U.M.W. hospitals in Kentucky, Virginia and West Virginia.

Curtis and Davis, New Orleans architects, received honorable mention for their plan of the proposed children's clinic for Dr. Wallace Sako, pediatrician of Raceland, La. Others receiving honorable mention were: the proposed Josephine Traylor Brooking Memorial Nurses' Home at Wharton, Tex., designed by Fehr and Granger of Austin; the proposed Albert Einstein College of Medicine in the Bronx, New York City, for which Kelly and Gruzen were the architects and engineers; the Doctors' Medical Center in Bellevue, Wash., Paul Hayden Kirk, architect; the proposed children's ward at the Georgia Warm Springs Foundation, Toombs and Company, Atlanta, architects; the Houston Center Medical Building, Houston, Tex., Golemon and Rolfe, architects, and the proposed Professional Building for the Georgia Baptist Hospital in Atlanta designed by Stevens and Wilkinson of that city.

Awards were made at a banquet held in Boston under the auspices of the Massachusetts State Association of Architects and the Boston Society of Architects. Prize winning designs were featured in the January issue of *Progressive Architecure.*

Nursing Film Exhibited

NEW YORK. — The Committee on Careers of the National League for Nursing premiered its nurse recruitment film, "When You Choose Nursing," at Lenox Hill Hospital here.

The film portrays the work and play opportunities of four nurses in the fields of pediatrics, teaching, industry and public health. It will be made available to 53 state and regional careers committees.

Save time and steps for nurses with CRANE

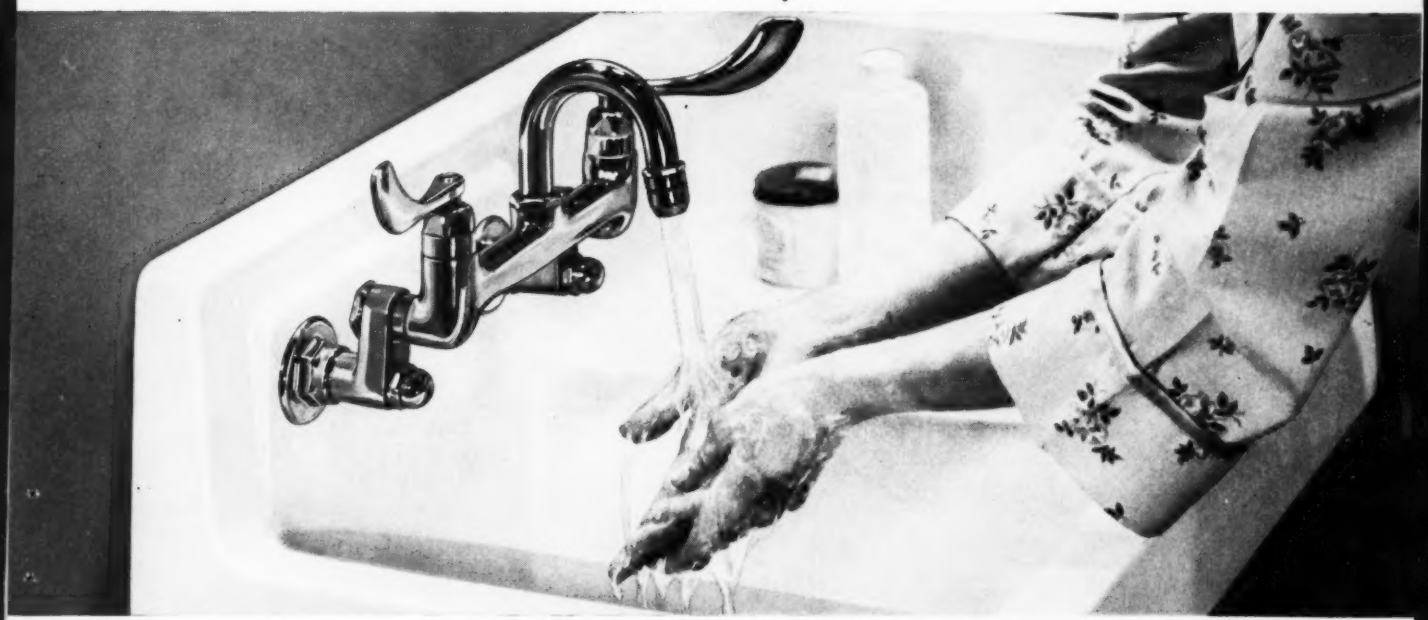
In hospital after hospital, the nursepower shortage has been relieved by the effective use of Crane specialized plumbing fixtures. That's because the right fixtures, properly placed, help ease the nursing shortage by . . .

Crane Hygiene lavatory can be placed in either corner of the patient's room or bathroom, or along the wall.

(1) *Removing much lost motion, hundreds of needless steps, and many unnecessary tasks from a nurse's day.*

(2) *Aiding in making the profession of nursing more attractive by making the work easier, faster, more pleasant.*

Developed with the help of hospital experts to meet specific hospital needs, Crane fixtures conform to the best in good hospital practice and sound hospital management.



New Crane fixture encourages patients to care for themselves

Specially designed for installation in patients' rooms and wards, Crane's new Hygiene Lavatory is equipped with wrist-action Dial-ese controls. And it has an integral shelf for water pitcher, toilet articles, and other patient needs.

By being conveniently near and easy to use, it is a standing invitation to convalescent patients to care for themselves instead of ringing for a nurse.

The Hygiene is the only lavatory especially made for patients' use, and is a good example of the way Crane meets specific hospital needs with specialized design.

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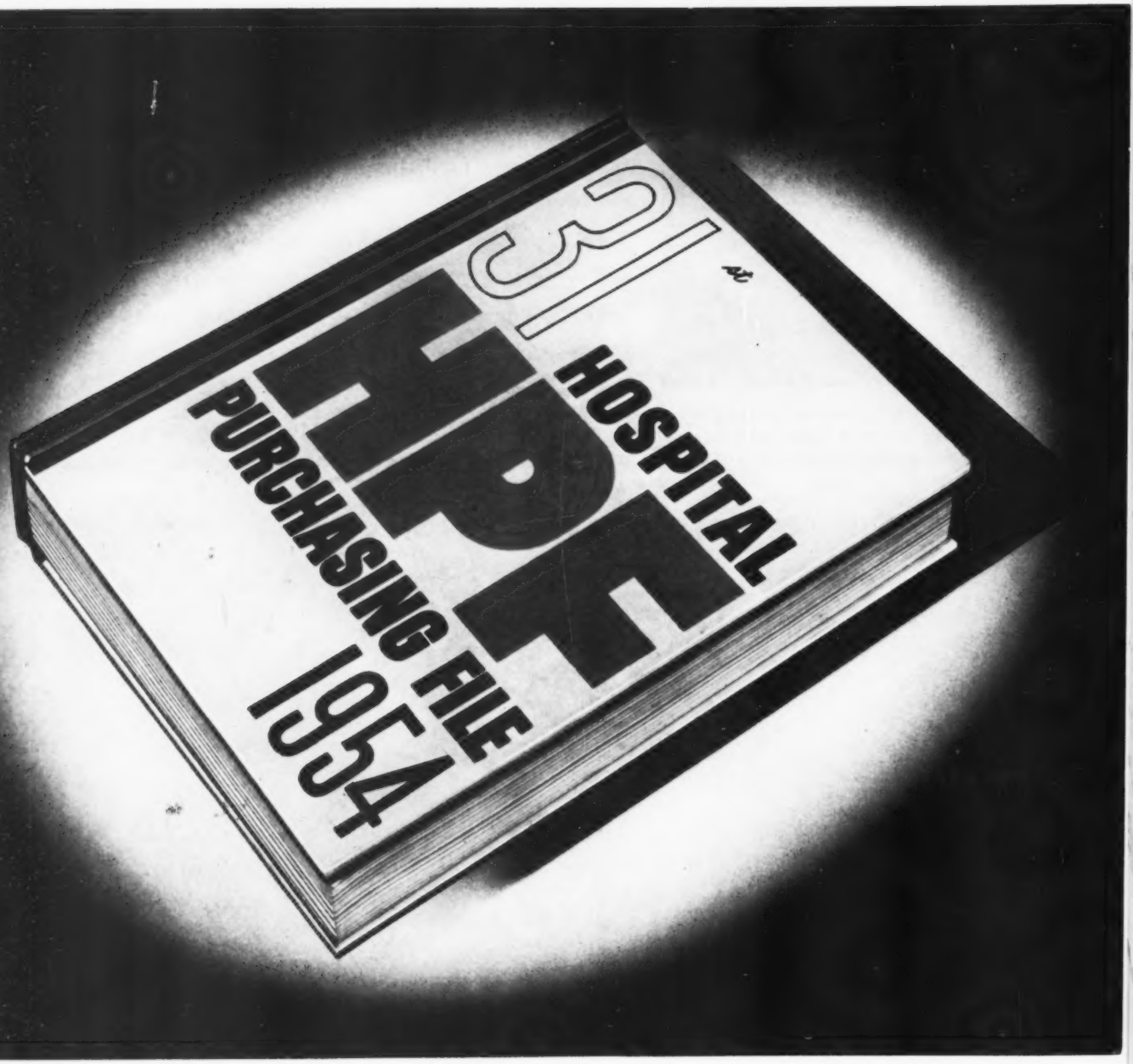

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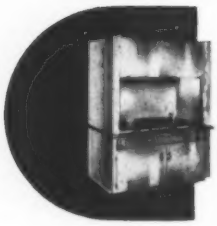

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NEWS...

Announce Plans for Expansion of Yale and Grace Hospital Center

NEW HAVEN, CONN.—Grace-New Haven Community Hospital here and the school of medicine of Yale University have announced plans for expansion of their cooperative arrangement into a major medical center similar in concept to the Columbia-Presbyterian Medical Center in New York City.

The joint announcement was made here on February 3 by President A. Whitney Griswold of Yale University and President George S. Stevenson of the Grace-New Haven Community Hospital. They explained that an immediate objective of the Yale-New Haven Medical Center Plan will be the carrying out of a program of public relations, fund-raising promotion, and program development. Both will retain corporate independence, it was made clear, in the development of a program for the care of patients and for medical research and teaching.

The new setup will include Yale's school of nursing, Psychiatric Institute, Department of Public Health, and Child Study Center, as well as the school of medicine.

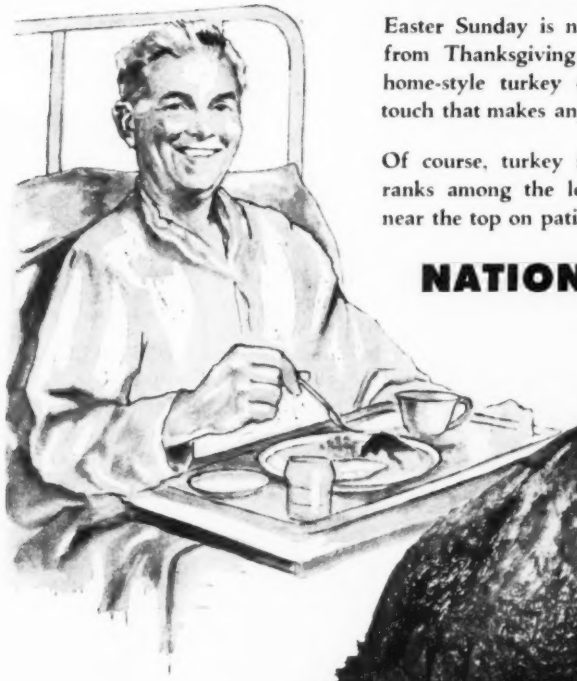
A nine-member advisory committee on program development has also been appointed. Members are: Dr. Vernon W. Lippard, dean of the school of medicine; Dr. Albert W. Snoke, director of the hospital; Elizabeth S. Bixler, dean of the Yale school of nursing; G. Harold Welch, New Haven banker and hospital trustee; Charles M. O'Hearn, assistant to the president of Yale; Dr. Gustaf E. Lindskog, professor of surgery; Robert E. Ramsay, president of the New Haven Gas Company and hospital trustee; Dr. Luther K. Musselman, chief of the hospital's general service staff, and Reginald G. Coombe, New York bank executive, who is vice chairman of the university council and chairman of its medical affairs committee.

Vote $350,000,000 Bond Issue for Mental Hospitals

ALBANY, N.Y.—The New York State Senate voted unanimous approval in January of a $350,000,000 state bond issue for mental hospital construction which now requires ratification by the voters at a referendum next fall before it can become effective.

This Easter.. Follow the trend to TURKEY

APRIL 18



Easter Sunday is now the third big "turkey day" . . . just far enough away from Thanksgiving and Christmas so your patients will really appreciate a home-style turkey dinner with all the trimmings. Turkey adds the festive touch that makes any holiday a special occasion.

Of course, turkey is a year-around favorite in many hospitals. It not only ranks among the lowest per portion costs of all quality meats, but it's also near the top on patient preference lists for meats.

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Mount Morris, Ill.

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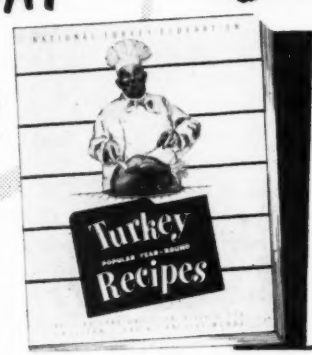

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ABOUT PEOPLE

(*Continued From Page 96*)


William S. Murphy

William S. Murphy, administrator of Somerset City Hospital, Somerset, Ky., for the last five years, has resigned to become administrator at Good Samaritan Hospital, Lexington, Ky., effective April 15. He succeeds **Walter B. Phelps.** Mr. Murphy, a nominee of the American College of Hospital Administrators, has served as director and first vice president of the Kentucky Hospital Association and is a member of the Blue Cross Advisory Council of Kentucky. For the last two years, he has been president of the Blue Grass Hospital Conference, and, for the last three, president of the T. B. County Association.


John H. Beddow

John H. Beddow, executive director of West Hudson Hospital, Kearny, N.J., has been named successor to **Robert H. Schnitzer,** director of Middlesex General Hospital, New Brunswick, N.J. Mr. Schnitzer has joined the staff of the New Jersey Blue Cross Plan as assistant director in charge of hospital relations. Mr. Beddow was formerly administrator of Brevard Hospital, Melbourne, Fla. He is a member of the American Hospital Association and the New Jersey Hospital Association.


Harry A. Blythe

Harry A. Blythe has resigned as director of City Memorial Hospital, Winston - Salem, N.C., to accept the administratorship of Eden Township Hospital District, Castro Valley, Calif., effective March 1. From 1946 until 1952, when he moved to Winston-Salem, he was assistant superintendent of the University of Chicago Clinics. He holds a master's degree in hospital administration from Northwestern University and is a member of the American College of Hospital Administrators.

Ralph Carley has succeeded **Eva H. Erickson** as administrator of Galesburg Cottage Hospital, Galesburg, Ill. He has been associated with the hospital for many years as a member of its board of trustees.


David J. Wires

David J. Wires, administrative assistant of Children's Hospital, Columbus, Ohio, has resigned to become administrator of Galion City Hospital, Galion, Ohio.

Brother Constantine has been appointed administrator of Alexian Brothers Hospital, Chicago, succeeding **Brother Julian.**


Charles G. Lohr

Charles G. Lohr has been appointed assistant director of Barnes Hospital, St. Louis. He earned his master's degree in hospital administration at Washington University and served his internship at Fort Sam Houston, Tex.

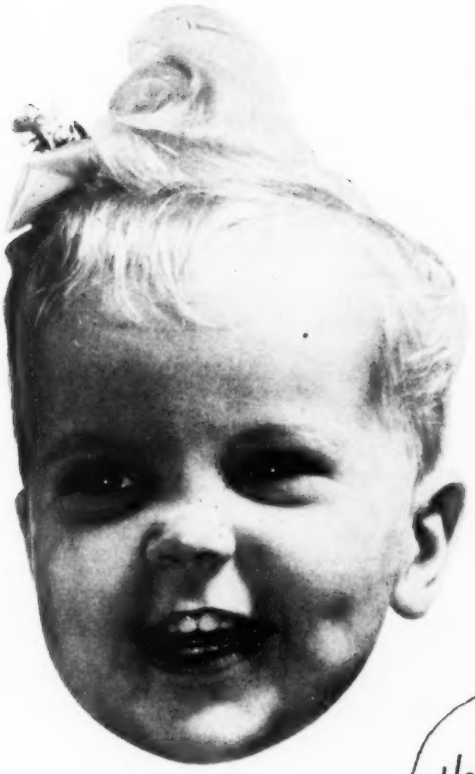
Benny Carlisle has been named administrator of Washington County Hospital, Fayetteville, Ark. He succeeds **George Berryman,** who has become administrator of an industrial hospital in New Brunsfield, Tex.


Vernon D. Seifert

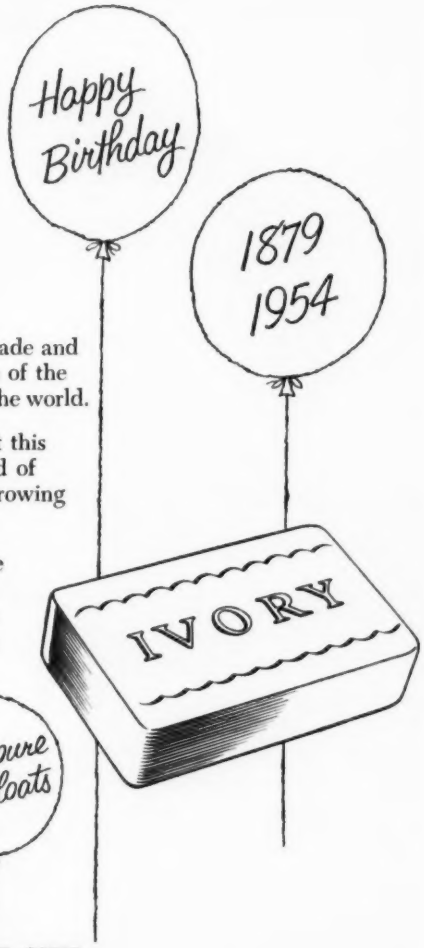
Vernon D. Seifert, assistant superintendent of Fairview Park Hospital, Cleveland, since August 1951, is now administrator of the hospital, succeeding **Philip Vollmer Jr.,** who has retired. Mr. Vollmer, who has been administrator of the hospital for 30 years, will continue his service to the hospital through his activities on the governing board. Prior to joining the hospital Mr. Siefert served as administrative assistant at Evanston Hospital, Evanston, Ill., and director of clinics and assistant to the medical director at St. Luke's Hospital, Chicago. **Basil J. Valenti,** assistant superintendent at Fairview since March 1952, has been named assistant administrator.

Christopher Castle, administrative assistant of St. Francis Memorial Hospital, San Francisco, has been appointed administrator of Garden Hospital, San Francisco.

(*Continued on Page 186*)



75 years of growing younger



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S. David Kaufman

S. David Kaufman, assistant director and controller of Beth Israel Hospital, Boston, has resigned to open his own public accounting practice. Except for three and a half years from 1943 to 1947 when he was controller of Mount Sinai Hospital, New York City, he has been associated with Beth Israel since 1939.

Carl Rasmussen has been named director of Washington Minor Hospital, Tacoma, Wash. Formerly, he was office manager at Tacoma General Hospital, Tacoma, Wash.

Thomas Graham is the new administrator of Harris Hospital, Newport, Ark.

Sidney S. Lee has been appointed assistant director and adminstrator of the outpatient department at Beth Israel Hospital, Boston. Prior to his appointment, Mr. Lee was chief of venereal disease control units, Division of Communicable Disease, Ohio Department of Public Health.

Sterling L. Platt has been named assistant director of Jewish Hospital of Brooklyn, Brooklyn, N.Y., where he was formerly controller. He is a member of the American Hospital Association and an associate of the faculty of the United Hospital Fund.


Miriam Lovell Neff

Miriam Lovell Neff, administrative associate of the University Hospitals, Iowa City, Iowa, since September 1952, has received a doctor of philosophy degree in hospital administration from the State University of Iowa. Dr. Neff is the third person to receive the degree.

Joseph Carmical, former business manager of St. Mary's Hospital, Dermott, Ark., has accepted the position of administrator of Bradley County Hospital, Warren, Ark.

Geoffrey B. Torney has been appointed administrator of Underwood Hospital, Woodbury, N.J. He holds a master of hospital administration degree received from Yale University.

W. U. Paul, administrator of Southwestern General Hospital, El Paso, Tex., since 1942, has resigned to establish a pharmacy. He is president of the Texas Hospital Association and has served as president of the Texas Pharmaceutical Association, the Northwest Texas Hospital Association, and the El Paso and Southern New Mexico Hospital Council. He is a member of the American College of Hospital Administrators.

Jack Rue, administrator of Kingfisher Community Hospital, Kingfisher, Okla., resigned recently because of ill health.

C. C. Hooper has been named superintendent of City Hospital, Magnolia, Ark. He succeeds **John Cherry,** superintendent since February 1952.

James R. Clark, administrator of Brooklyn Hospital, Brooklyn, N.Y., who has been first vice president of the Hospital Association of New York State, has succeeded to the presidency of the association with the resignation of **Dr. James E. Fish,** who is leaving the state.

Leslie Nash is the new administrator of Ord Cooperative Hospital, Ord, Neb., succeeding **Frank Perry.**

Emma Cavanaugh, supervisor of Nevada City Hospital, Nevada, Mo., since 1937, is retiring effective March 1. Her successor is **Roda M. Wall,** super-


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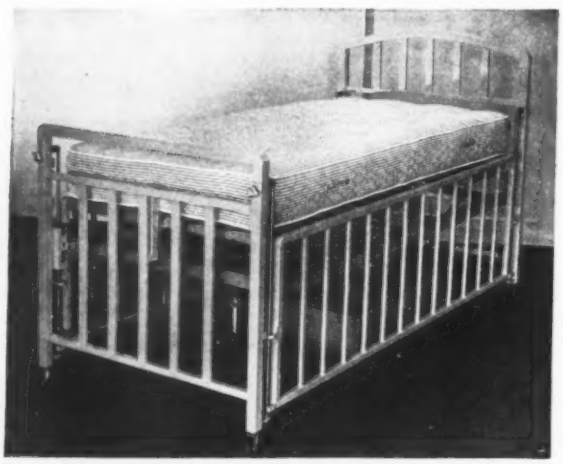

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intendent of Lutheran Hospital, Buffalo, Wyo.

Gen. Alvin L. Gorby

Brig. Gen. Alvin L. Gorby has been named deputy commander of Walter Reed Army Medical Center, Washington, D.C. For the last year, he has been director for planning and liaison and senior medical adviser in the office of the assistant to the Secretary of Defense.

Dr. August H. Groeschel, executive director of Philadelphia General Hospital, has resigned to accept a position with the New York Hospital, New York City.

Karenza Gilfoy, administrator of Mississippi Baptist Hospital, Jackson, Miss., has resigned.

Robert E. Jones, administrator of Hiawatha Community Hospital, Hiawatha, Kan., has resigned to accept a similar position at Miami County Hospital under construction at Paola, Kan.

Dr. J. Melvin Boykin, chief of professional services at the V.A. Hospital at Richmond, Va., has been named manager of the V.A. Hospital, Lincoln, Neb. Since his discharge from the army in 1946, Dr. Boykin has been chief of medical services at the V.A. Hospital, Alexandria, Va., and at the V.A. Hospital, Temple, Tex.

Nick Rajacich

Nick Rajacich, former administrative assistant at Johns Hopkins Hospital, Baltimore, has been appointed assistant director of the hospital. Mr. Rajacich is a graduate of the University of Minnesota School of Public Health and Hospital Administration and was appointed administrative assistant in 1952, following a year's service as administrative resident.

Jack A. Skarupa

Jack A. Skarupa has been appointed assistant director of Greenville General Hospital, Greenville, S.C. A graduate of the University of Connecticut, Mr. Skarupa received his certificate in hospital administration from Duke University Hospital, Durham, N.C., last year.

(*Continued on Page* 190)

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Dr. Roger W. DeBusk, administrator of the Samuel Merritt Hospital at Oakland, Calif., since August 1952, has left that position. **Ellard L. Slack,** administrator of the hospital for many years prior to his retirement on account of ill health in 1952, has been reappointed. Before moving to Oakland in 1952, Dr. DeBusk was administrator of Lancaster General Hospital, Lancaster, Pa., and, previously, he was administrator of Evanston Hospital, Evanston, Ill.

Dr. Abraham G. Chelnik has been appointed medical director of Newark City Hospital, Newark, N.J. He succeeds **Dr. Phillip J. Santora,** who has been acting director.

Sister Patricia, administrator of St. Michael's Hospital, Newark, N.J., for the last six years, is now administrator of St. Francis Hospital, the Bronx, N.Y., succeeding **Sister Serathim,** who has been transferred to St. Michael's.

R. J. Weinzettel, assistant administrator of Mound Park Hospital, St. Petersburg, Fla., for the last three years, has been appointed administrator of Lee Memorial Hospital, Fort Myers, Fla., effective March 1. Mr. Weinzettel is an alumnus of Northwestern University's course in hospital administration.

J. P. Smith, since 1947 assistant administrator at Baptist Memorial Hospital, Memphis, Tenn., has been named administrator of the new Baptist Memorial Hospital under construction in Kansas City, Mo. Before going to Memphis, Mr. Smith had been assistant administrator of Southern Baptist Hospital, New Orleans. He is a former president of the Memphis Hospital Association and a former vice president of the Tennessee Hospital Association. Mr. Smith holds memberships in the American College of Hospital Administrators, the American Hospital Association, and the Southeastern Hospital Association. His new appointment is effective March 1.

Harold Horrocks, formerly administrative resident of East Orange General Hospital, East Orange, N.J., and administrative assistant of Jewish Hospital of Brooklyn, N.Y., has been appointed assistant administrator of Somerset Hospital, Somerville, N.J. He is a graduate of the course in hospital administration at Columbia University and is a member of the American Hospital Association.

Sister Virgine, administrator of St. Mary's Hospital, Hoboken, N.J., has been succeeded by **Sister M. Senana, R.N., M.S.,** formerly operating room supervisor at St. Francis Hospital, Jersey City, N.J. Sister Virgine has been assigned to St. Clare's Hospital, Schenectady, N.Y.

John T. Lindberg, administrator of Fairmount General Hospital, Fairmount, W. Va., is the new administrator of Atlantic City Hospital, Atlantic City, N.J., succeeding **Allan Bleam.**

C. J. Hassenauer, administrator of Garfield Park Community Hospital, Chicago, was feted by employes and members of the medical staff on the occasion of his twenty-fifth anniversary as head of the hospital February 18. Mr. Hassenauer is past president of the Chicago Hospital Association.

Department Heads


Jacques W. Bloch

Jacques W. Bloch has been appointed special assistant to the director of Montefiore Hospital, New York City, in charge of food service. Prior to going to Montefiore, he had been food

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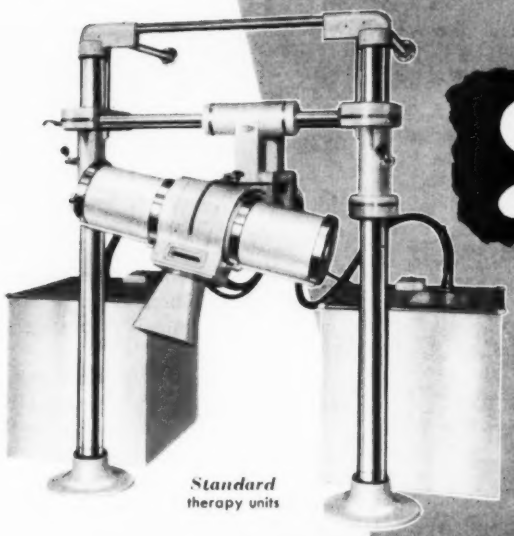

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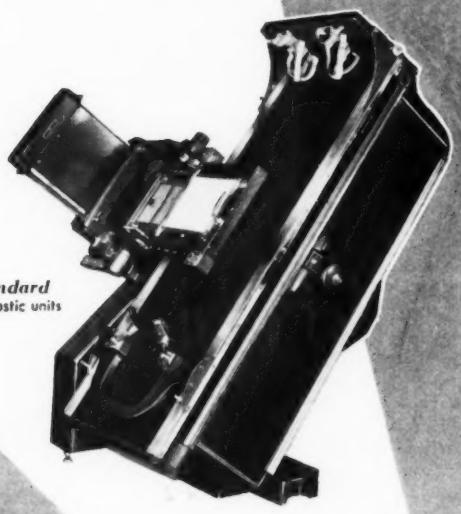

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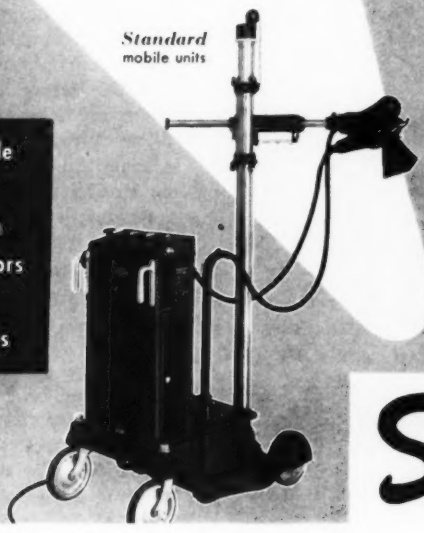

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- DO-300 Generator 300 MA at 100 PKV; 10 MA at 110 PKV
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production manager at Johns Hopkins Hospital, Baltimore, for four years. At the same time he was an instructor in institutional food purchasing and menu planning at McCoy College. Mr. Bloch is a graduate of the College Technique Hotelier, Strasbourg, France.

Trustees

Albert P. Gerhard, after nearly a half century of service on the board of managers of Children's Hospital, Philadelphia, has retired. Since becoming a member of the board in 1906, Mr. Gerhard has been chairman of the fund raising committee to finance the building of the present hospital erected in 1916, and has served as assistant secretary, assistant treasurer, vice president and president of the board.

Deaths

Walter P. Burrier, 71, former manager and clinical director of the V.A. Hospital at Bedford, Mass., died in January. He had also served at the V.A. hospitals in Boston and the Bronx, and at the diagnostic center in Washington, D.C., and the V.A. Hospital at Northampton, Mass.

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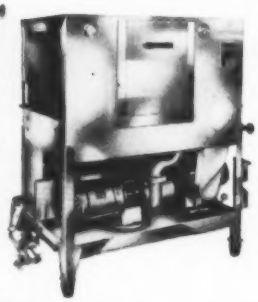

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THE BOOK SHELF

PAYING FOR MEDICAL CARE IN THE UNITED STATES, *by Dr. Oscar Serbein Jr. New York: Columbia University Press,* 1953.

Sponsored by the Health Information Foundation this study was designed to make better known the latest developments in voluntary hospital, surgical and medical care insurance and to provide information needed to help improve insurance coverage and benefits.

Based on a house-to-house canvass of 2809 families representing a validated sample of the national population, this is the first country-wide survey of its kind since the series of studies conducted by the Committee on the Costs of Medical Care from 1928 to 1932.

The purposes of the Foundation's project are: (1) to discover the relationship between family medical costs and illness, the bearing prepaid health insurance plans have on this relationship, and attitudes toward health needs and insurance, and (2) to study family debt in relation to illness to learn if debts are related to medical costs or to other financial obligations and if lack of insurance is a factor.

THE MEDICAL STAFF IN THE HOSPITAL. *By T. R. Ponton, M.D., as Revised by Malcolm T. MacEachern, M.D. Chicago: Physicians' Record Company,* 1953. $7.25.

This is "must" reading for students in university programs in hospital administration, hospital administrators, trustees of hospitals, and doctors on attending staffs of hospitals. In the foreword Dr. Harvey Agnew indicates the importance of this book when he says, "Some of the most difficult problems in administration have been related to the medical staff or its members and, conversely, it is frequently within the power of the medical staff to solve most effectively many of the major problems of a hospital."

Chapter I, on "The Governing Body and the Medical Staff of the Hospital," is excellent, although it seems to me that Figure 2 on Page 3 does not accurately portray relationships. I believe the administrator should be shown immediately under the governing board as being its responsible representative for all of the functions fulfilled through

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administration or the medical staff. In this same chart the block on the medical staff side says, "cooperate with the administration," and another block says, "cooperate with the governing body." It seems to me this should read, "cooperate with and be responsible to the governing body through the administrator." Not until all elements in the hospital team realize that the administrator is the chief executive officer of the board of trustees and is responsible for everything in the hospital, including the medical staff, will we begin to improve the fundamental organization and operation of hospitals.

The statement regarding the obligations of the governing body to support the efforts of the medical staff, under the subheading, "Enforcement of By-Laws, Rules and Regulations of the Medical Staff," does not, in my opinion, go far enough. The statement should have included the fact that the governing body must be certain that the organized medical staff is supervising and, when necessary, disciplining members who are not performing their duties properly, and should further point out that if the medical staff does not act to discipline its members, the board of trustees must step in and force action. However, the general discussion of the mutual responsibility of the governing body, the medical staff, and the administrator is excellent and, it is hoped, will prove a guide to future organization and operational problems in hospitals.

In discussing the responsibility of the individual doctor in treating his patients, the statement is made that "He is the sole authority in ordering treatment for the individual patient and is not subject to interference." It does not appear that this statement is practical in the light of necessity. There certainly are occasions when an individual doctor must bow to the chief of his department and/or the chief of staff on certain matters relating to the private physician's care of his patient.

Chapter II, covering the physician in the hospital, is most interesting. However, the discussion on the economic phase of the practice of medicine in the hospital gets somewhat involved and statements are contradictory in some instances. Inasmuch as this controversial subject, particularly the relationship of specialists such as the pathologist and radiologist with the hospital, has been so widely discussed in late years and there are so many different opinions on the subject, it is not to be wondered at that the author of the book has found it difficult to make clear his thinking on this point.

The statement in this chapter that "Organized medicine is waging a constant battle against this unethical bartering [fee splitting]* in medical services with a reasonable degree of success, but there are and always will be some unscrupulous physicians, and constant vigilance is needed" is, of course, most interesting, but experience indicates that the battle has not been overly successful. This chapter is excellent, however, and will certainly cause anyone reading it to do some constructive thinking; it should stimulate hospital administrators, trustees and attending staff members into proper action.

Chapter III, on selection and appointment of the medical staff, is probably the finest in the book, and should provide a splendid guide for everyone who has responsibility for the appointment of individual staff members to the staff of any hospital. The place of the administrator in the procedure

*Reviewer's note.

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is carefully outlined and seems to put the administrator in his proper place of administrative authority.

If all hospital staff members would read Chapter IV, covering organization of the medical staff, the lives of hospital administrators and trustees would be eased a great deal. The section in this chapter covering the chief of staff is most interesting. With regard to the discussion of the various methods by which the chief of staff gets into office, I believe that the governing body should definitely have final approval. Too many chiefs of staff are elected by the attending staff on a political basis, and it seems obvious that final approval by the board of trustees would provide an excellent deterrent to purely political action in putting a chief of staff in office. This discussion might also have included some of the reasons why a term of office for a chief of staff longer than one year is advisable. It takes a year for even a good chief of staff to be oriented to his job, and it seems too bad to have him go out of office before he is ready to handle the job properly. In this same chapter the author advocates that chiefs of the various clinical services be elected by the members of those services. Here again, I think this is a mistake, and that the chapter should have included discussion on the possibility of the chiefs of services being subject to final approval by the board of trustees. In many hospitals the various services nominate not less than two candidates to the board of trustees for appointment. Inasmuch as the board of trustees is responsible for everything that goes on in the hospital, it seems essential that this board have final approval power for all chiefs of services and the chief of staff.

Chapters V, VI and VII deal with by-laws, meetings of the medical staff, and medical records. All of these chapters are excellent, and will provide the finest kind of guidance for those responsible for the organization of hospital medical staffs.

Chapter VIII, covering professional accounting and the medical audit, is important and extremely well done. In discussing the relationships and differences of financial and professional accounting and auditing, the author says, "The problems are comparatively simple in the administrative division." Some hospital administrators would question this particular statement. The section of this chapter which deals with the control of surgery is splendid, and gives a straightforward look at the problems involved. In this chapter on professional accounting and medical audits the author gives this subject the prominence it deserves in hospital operation. If hospital administrators, trustees and attending staff doctors followed the outlined program in the last chapter, covering the resident medical staff, I'm sure that residents and interns would have a better educational experience in hospitals.

The excellent material covered in the addenda section brings together in one place authoritative information on the essentials of approved internships and residencies in both the United States and Canada, standards for hospital accreditation of the new Joint Commission on Accreditation of Hospitals, suggested outlines for by-laws, rules and regulations of medical staffs in hospitals of various sizes, and other important pertinent data.

Dr. MacEachern is to be congratulated on this, one of his most important contributions to the field of hospital literature.

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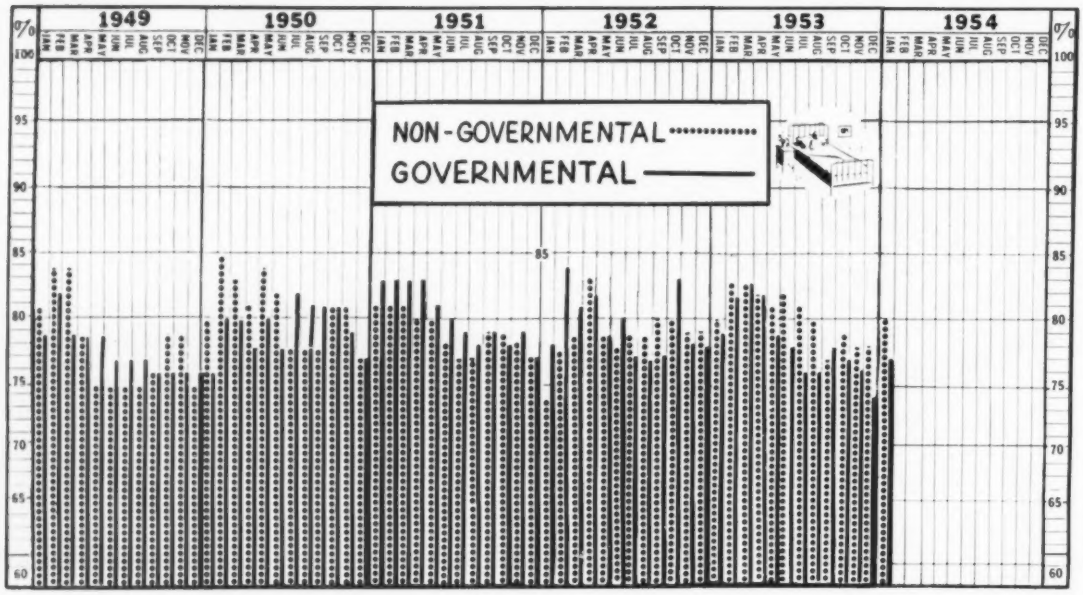

Governmental and nongovernmental hospital reports to the Occupancy Chart for January show a decline from the occupancies of a year ago. At that time figures reported were 81 and 83.1 per cent, respectively; this year the percentages reported were 77 and 79.5.

Construction of new hospital facilities from January 25 through February 8 totaled $87,383,242, bringing construction to date to $106,966,732.

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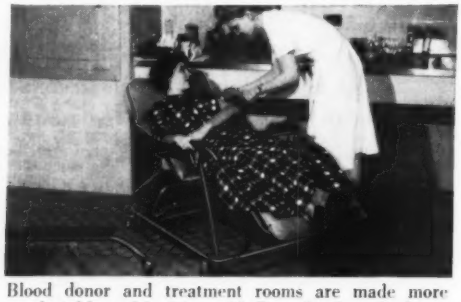

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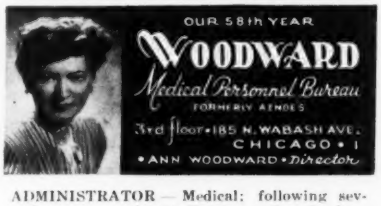

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(Continued on page 202)

INTERSTATE—*Continued*

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(Continued on page 204)

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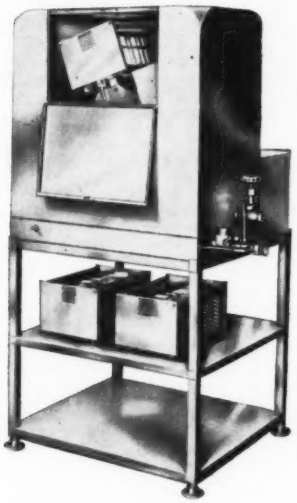

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DIRECTRESS OF NURSES — 300-bed fully approved general hospital with accredited school of nursing; located in a beautiful resort city; personnel policies in accordance with S.N.A.; Degree in Nursing Education required; full maintenance; salary open. Apply, Atlantic City Hospital, Atlantic City, New Jersey.

HOUSEKEEPER—Executive, hospital; salary $5652 to $7100 per year; excellent opportunity under merit system at Philadelphia's general hospital; high school graduate with five years' experience in institutional housekeeping, including three in management; supervise large staff. For further information, write to Personnel Department, Room 127, City Hall, Philadelphia 7, Pennsylvania.

INSTRUCTOR—Science; approved school of nursing has excellent opportunity for qualified science instructor; fine, modern equipment; living accommodations available; salary open; pension plan; travel arrangements for interview. Apply to Personnel Director, The Christ Hospital, 2139 Auburn Avenue, Cincinnati, Ohio.

INSTRUCTOR—Clinical, medical-surgical; 155-bed general hospital; 75-bed addition in near future; salary $260 per month with complete maintenance; good personnel policies; 44-hour week. Apply, Director of Nurses, Chesapeake and Ohio Hospital, Clifton Forge, Virginia.

INSTRUCTOR—Clinical, medical and surgical; for 350-bed general hospiltal; school of 125 students; degree and some experience in this field required; salary commensurate with preparation and experience. Apply: Director of Nursing, York Hospital, York, Pennsylvania.

INSTRUCTOR — Public health; Degree required, preferably in Nursing Education; 41½-hour, 5½-day week; salary open; 251-bed hospital; current staff of 6 full-time instructors. Apply, Director of School of Nursing Education, Mound Park Hospital, St. Petersburg, Florida.

INSTRUCTOR — Nursing arts; in approved school of nursing in 320-bed general hospital; Degree in Nursing Education required, experience desired; 44-hour week; vacation, sick leave, paid holidays; salary open. Apply, Director of Nurses, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Record; for 100-bed hospital; 40-hour work week; liberal personnel policies; salary $275 per month. Apply, Director of Nurses, St. Mary's Hospital, Green Bay, Wisconsin.

LIBRARIANS—Medical records, or experienced records personnel; fully approved 500-bed hospital in Pennsylvania with sound medical and record room standards; all replies held confidential. Apply, MO 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS — Staff physician, experienced in surgery, who can also do general medical and other duties required in a mental institution: two Graduate nurses and one Laboratory technologist. If interested, contact Medical Director, Florida State Hospital, Arcadia, Florida.

MISCELLANEOUS — Psychiatric supervisor, Clinical instructor and Administrative supervisor; 483-bed general hospital with school of nursing nationally accredited; salary open depending upon experience; 40-hour week. Write to Director of Nursing, Butterworth Hospital, Grand Rapids, Michigan.

MISCELLANEOUS — Qualified Laboratory technologist, experienced Supervisors, and Dietitian, for 100-bed hospital. For particulars apply to Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

MISCELLANEOUS — Assistant director of nurses, Supervisors and Head nurses for 2200-bed psychiatric hospital; salary depends on experience and qualifications; additional Staff needed for Educational and Therapeutic programs. For particulars apply to Personnel Director, Central State Hospital, Indianapolis 22, Indiana.

NURSES—General duty; also 11-7 Supervisor for nursing office; 100-bed general hospital; alternating shifts. Address, Director of Nurses, Martinsville General Hospital, Martinsville, Virginia.

(Continued on page 206)

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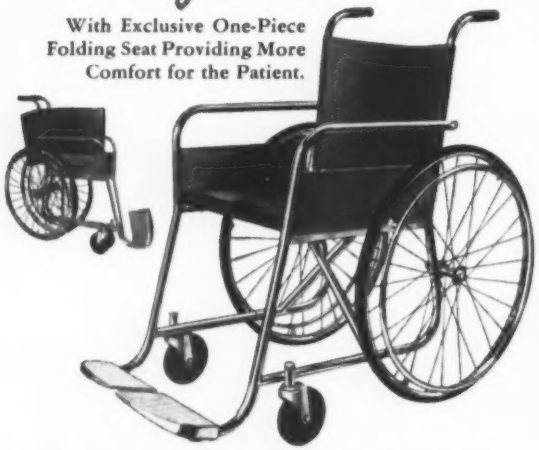

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NURSES—Graduate; for hospital located near beautiful Lake George; salary with complete maintenance; $10 differential afternoon and night duty; 8-hour day, 5-day week; time-and-one-half for overtime. Moses-Ludington Hospital, Ticonderoga, New York.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Registered; for 1700-bed state mental hospital, 50 miles from Kansas City, Missouri, Highway 169; some experience in psychiatric nursing preferred, although not absolutely essential; salary range from $231 to $530 per month, depending on experience and qualifications; annual leave and sick leave benefits; living accommodations available. Apply, Wilbur G. Jenkins, M.D., Superintendent, Osawatomie State Hospital, Osawatomie, Kansas.

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

OFFICE MANAGER—70-bed hospital in city of 12,000 in western Ohio; man or woman; retirement benefits; salary from $280 monthly and up, according to experience and ability; secure future; your inquiry strictly confidential if you desire. Write, MO 71, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PHYSICAL THERAPIST — Registered; 160-bed general hospital in town of 24,000; modern facilities; salary commensurate with experience; good personnel policies. Write, Administrator, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

PHYSICIAN — California licensed for health department tuberculosis clinic; requirements: minimum 2 years experience in diagnosis and/or treatment of tuberculous patients; age limit 54; salary $786 monthly, 40-hour week. Further details and application available from County Civil Service, 402 Civic Center, San Diego, California.

PSYCHIATRIST—CLINICAL DIRECTOR. For a 30-bed, private hospital, fully equipped for diagnostic work plus outpatient clinic; minimum starting salary $12,000. Reply, MO 75, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SECRETARY—Medical; for 180-bed hospital in midwestern city of 200,000; knowledge of medical terminology; takes dictation of medical reports and letters, prepares periodic reports, maintains files, part-time records librarian, performs related clerical duties; pleasant surroundings; paid vacations; salary commensurate with experience and qualifications. Reply, MO 54, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 207)

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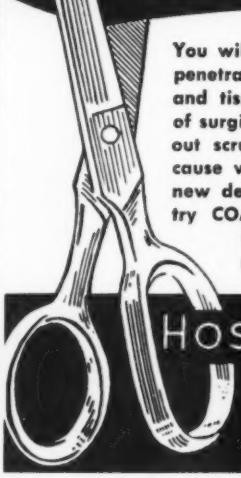

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SUPERVISOR—Operating room; 250-bed hospital with a school of nursing; salary open; supervisory experience and postgraduate work required. Apply, Director of Nursing Service, Mound Park Hospital, St. Petersburg, Florida.

SUPERVISOR—Operating room; for 350-bed general hospital; degree preferred, person with at least several years experience in this field essential; salary open. Apply: Director of Nursing, York Hospiltal, York, Pennsylvania.

SUPERVISOR AND INSTRUCTOR—Operating room supervisor and clinical instructor for modern 250-bed hospital and school of nursing, 70 miles from New York City; fully approved; forty-hour week; four weeks paid vacation; sick time; hospital care; complete maintenance at $45 per month; salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISORS — Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

TECHNICIAN—Laboratory; for new 237-bed general modern hospital, 28 miles from New York City; salary commensurate with ability and experience; liberal employee benefits. Contact Director of Personnel, Greenwich Hospital, Greenwich, Connecticut.

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(Continued on page 208)

MEDICAL BUREAU—*Continued*

(f) Director of administrative services; new 500-bed hospital affiliated medical school; formal training, experience required; university center, east. (g) Assistant director; university hospital, 300 beds; plans completed for new medical center which include hospital of considerably greater capacity. MH3-1

ADMINISTRATORS—NURSES. (a) Voluntary general hospital, completed 1941; 80 beds; resort town, east. (b) Small general hospital; completion June; $7000-$8000. MH3-2

ANESTHETISTS — (a) Director, school of anesthesia; degree, considerable experience desired; 500-bed general hospital; $7000. (b) General hospital; new wing recently increased capacity to 500; New England; $400-$500. (c) Association, 10-man group; university city, southwest. (d) New hospital, 300 beds; large city, Pacific coast; $450-$500. MH3-3

DIETITIANS—(a) Food service director by university; duties include teaching courses in institutional management; Master's required; will have charge of college cafeteria, food service, two dormitories. (b) Chief dietitian; university hospital, 300 beds; plans completed for new medical center including hospital of considerably greater capacity. (c) Therapeutic dietitian; general hospital; Los Angeles area. (d) Chief; 200-bed general hospital; vicinity New York City. (e) Chief; large teaching hospital; Pacific coast. MH3-4

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES — (a) Teaching hospital, 700 beds; one of country's leading schools of nursing; 300 students; facilities of the best; new nurses' residence; east. (b) General 475-bed hospital; 170 students; all departments well staffed; interesting city outside continental United States; although tropical country, mild pleasant climate. (c) Voluntary general hospital, 410 beds; 170 students; departments well staffed; university city, midwest. (d) Psychiatric hospital; teaching program; outside continental United States. (e) Director of nursing service; new hospital, small size, for medical cases only; no chronic patients; California. (f) Director nursing service; university hospital, 300 beds; plans completed for new medical center which include hospital of considerably greater capacity. (g) Nursing service only; general 250-bed hospital; succeed director retiring after 20 years; California. MH3-5

EXECUTIVE HOUSEKEEPER—Public institution, 2000 beds; $5600-$7100. MH3-6

EXECUTIVE PERSONNEL—(a) Comptroller, qualified direct staff of 22; 600-bed teaching hospital; university center, midwest; $6000-$8000. (b) Personnel director; general 550-bed hospital; 900 employees; east. (c) Purchasing director; extensive experience on administrative level required; large teaching hospital. (d) Hospital engineer; degree, construction experience desired; medical center expansion program. MH3-7

EXECUTIVE SECRETARY — Professional nurses' association; degree required. MH3-8

FACULTY POSTS—(a) Chairman, university nursing education department currently being instituted; qualified faculty in sciences, humanities, general education will contribute to program; up to $9000. (b) Educational director; university hospital; Asia. (c) Assistant professors in neuro-psychiatric, obstetrical, medical, surgical nursing; four-year program; leading university. (d) Science instructor; large school; vicinity New York City; $4600. (e) Clinical instructors, medical and surgical, nursing arts; 350-bed hospital; 160 students; university city; $3800-$5100. MH3-9

MEDICAL RECORD LIBRARIANS—(a) Chief, medical record section; new medical center; competent organizer required; $5000-$6500. (b) Chief; university group; unusual opportunity; large city, university center, west. MH3-10

NEUROSURGICAL NURSE—To serve as office nurse to Board neurosurgeon; university city. MH3-11

(Continued on page 209)

MEDICAL BUREAU—*Continued*

STAFF AND SURGICAL—(a) Large teaching hospital; opportunity continuing studies; south. (b) Staff; Pacific Islands; $4290, apartment (shared), transportation. MH3-12

SUPERVISORS—(a) Operating room; large teaching hospital; 38 staff; university city, Pacific coast. (b) Obstetric; new 500-bed hospital affiliated medical school; mid-south. (c) Operating room; new 350-bed hospital affiliated diagnostic clinic; staff of distinguished specialists; residential town, near several large cities; east; $5000. (d) Medical; new unit, university group; midwest; $360-$495. (e) Surgical; large general hospital outside United States; although tropical country, climate mild. (f) Pediatric; 40-bed department, 300-bed hospital; college town, Pacific Northwest. (g) Operating room; 400-bed hospital; extensive experience, teaching ability required; $5900 increasing to $6500 second year. (h) Psychiatric; new 20-bed department; 200-bed hospital; Pacific Northwest. MH3-13

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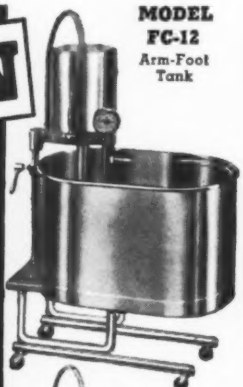

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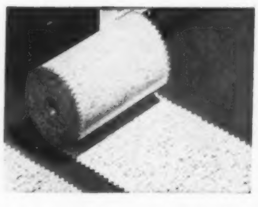

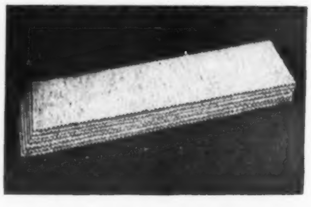

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POSITIONS OPEN

SHAY—*Continued*

nance. (b) West: 250-bed hospital in city of 45,000; school of nursing has approximately 80 students; $6000 to $7200. (c) Middle west: 250-bed hospital, fully approved, located in city of 90,000; $6000 plus maintenance. (d) East: 100-bed general hospital, fully approved; modern in all respects; ideal living facilities; $6000 plus maintenance. (e) East: 125-bed hospital; excellent nursing staff; 25-30 students in school of nursing; $6000 plus maintenance which includes a lovely apartment. (f) East: 300-bed hospital, fully approved; student enrollment 150; $6000 plus a nice apartment and maintenance.

DIETITIANS—(a) Head; east; 500-bed general hospital; supervise teaching program; 70 employees in department; $5000-$6000. (b) Head; northwest; 200-bed general hospital, fully approved; located in city of 40,000; 30 in department. (c) Head; middle west; 225-bed general hospital located in a very progressive city; 2 large universities and splendid cultural and recreational facilities; $5000. (d) Assistant; middle west; 190-bed general hospital; must be qualified to handle special diets; 40 employees in department. (e) Head; south; 100-bed hospital; department is well staffed and has all latest and best equipment; new modern hospital located in pleasant college town; $4800. (f) Therapeutic; middle west; new, modern 300-bed hospital, fully approved; $3600.

SHAY—*Continued*

MEDICAL TECHNOLOGISTS—(a) Middle west; 350-bed hospital affiliated with university medical school; requires some training in biochemistry as will supervise this phase of laboratory procedure; $6000. (b) Chief; south; 125-bed hospital; must be capable of teaching and have good administrative experience; $350-$450. (c) Chief; middle west; 100-bed hospital; ASCP or eligible with training in bacteriology and parasitology; four in laboratory; $375-$425. (d) Southwest; 250-bed hospital in large city; prefer experience or interest in hematology; $300. (e) East; 275-bed hospital located in city of about 175,000; good experience in all general clinical laboratory procedures; $350.

ADMINISTRATORS—(a) Lay, assistant; voluntary general hospital, 200 beds; one of finest on west coast; opportunity succeeding present administrator short time. (b) Lay; able administrator, prefer experienced in domiciliary care; infirmary, 125 beds and, also, 33-bed rest home 15 miles distant; northwest. (c) Lay; excellent children's hospital, small size; college town 100,000; California. (d)

(Continued on page 210)

WOODWARD—*Continued*

Lay; general hospital, 100 beds; desirable town, California. (e) Medical; general hospital, 175 beds; 2 units; replacing both with one new unit 1955; northeast. (f) Lay; general hospital, 180 beds, municipally operated; south. (g) Medical; several units; 300 beds; teaching program; summer, winter resort city of South. (h) Lay; voluntary general hospital, 275 beds; building program underway; mideast. (i) Medical; direct teaching program; new post; voluntary hospital, 250 beds; $10-$12,000; opportunity same position near-by hospital; northeast. (j) Lay; voluntary general hospital, 250 beds; near New York City. (k) Medical; general voluntary hospital, 300 beds; prefer one trained internal medicine; east. (l) Lay; assistant; excellent general voluntary hositpal, 150 beds; Detroit area. (m) Medical; to direct broad program improving hospital care; important medical center and group 30 affiliated hospitals. (n) Lay; voluntary general hospital, 150 beds; Iowa.

EXECUTIVE PERSONNEL—(a) Accountant; qualified hospital accounting and costs; voluntary general hospital, 200 beds; work under outstanding administrator, FACHA; Detroit area. (b) Accountant; pay roll, accounts payable and general ledger; no credit collections; voluntary general hospital, 200 beds; administrator, FACHA; 1 hour to New York City. (c) Comptroller; 700 beds; medical school affiliation; to $10,000; New England. (d) Personnel director; organize and direct department; new post; voluntary general hospital; 300 beds; midwest. (e) Public relations officer;

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POSITIONS OPEN

WOODWARD—*Continued*

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NURSE ADMINISTRATORS—(a) 125-bed new modern hospital, east. (b) 80-bed hospital, Wisconsin. (c) 50-bed Ohio hospital; open June.

INTERSTATE—*Continued*

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PURCHASING AGENTS—(a) 500-bed Sisters' hospitals, midwest. (b) 225-bed hospital, Pennsylvania.

RECORD LIBRARIANS—(a) 400-bed hospital, near Cincinnati, $350. (b) 200-bed Pennsylvania hospital. (c) 150-bed Ohio hospital; $350.

X-RAY TECHNICIANS—(a) Chief; 400-bed hospital, Ohio. (b) 200-bed hospital, southwest.

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ANESTHETIST—250-bed hospital; $425 plus maintenance.

(Continued on page 211)

MEDICAL PERSONNEL EXCHANGE—*Continued*

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DIRECTOR OF NURSES—Mature; June 1; 88-bed hospital, Philadelphia vicinity; graduate staff; degree not required; attractive salary, maintenance, including 3-room apartment.

DIRECTOR OF OCCUPATIONAL THERAPY—Registered; large mental hospital; $5000.

EXECUTIVE HOUSEKEEPER—Large hospital, New York City; 40-hour week; salary open.

LIBRARIAN—Degree in Library Science required; $3600.

MEDICAL RECORD LIBRARIAN—Chief; 150-bed hospital; $3600 plus maintenance.

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(Continued on page 212)

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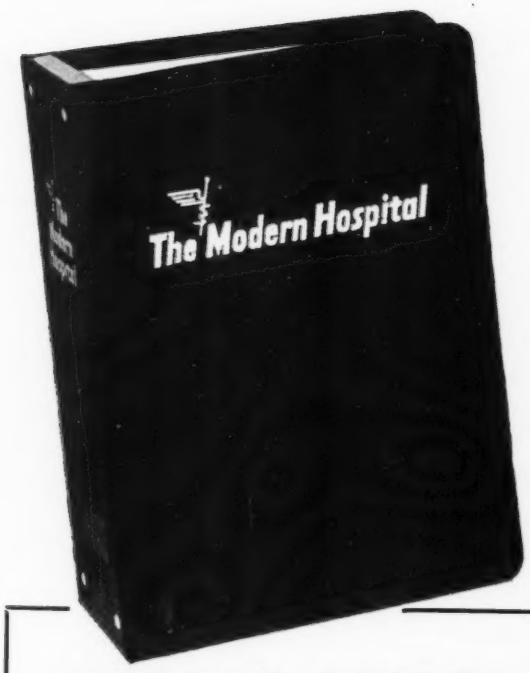

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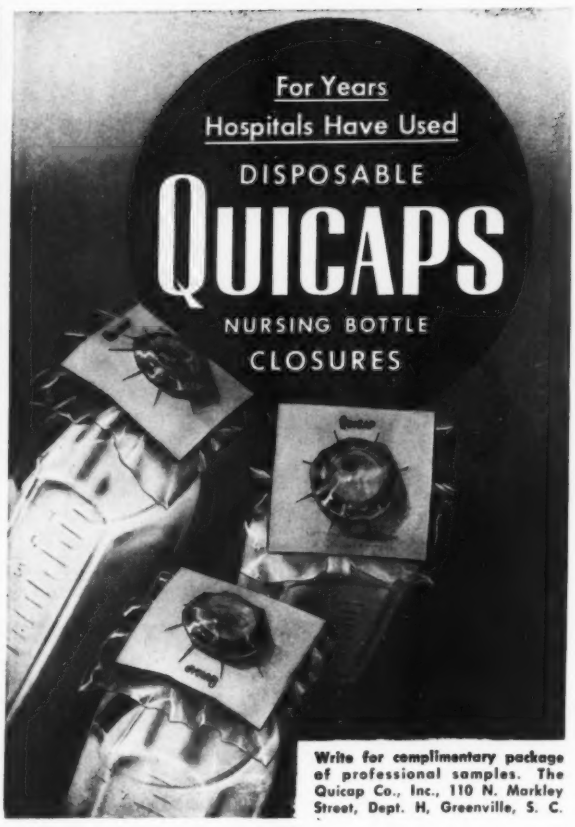

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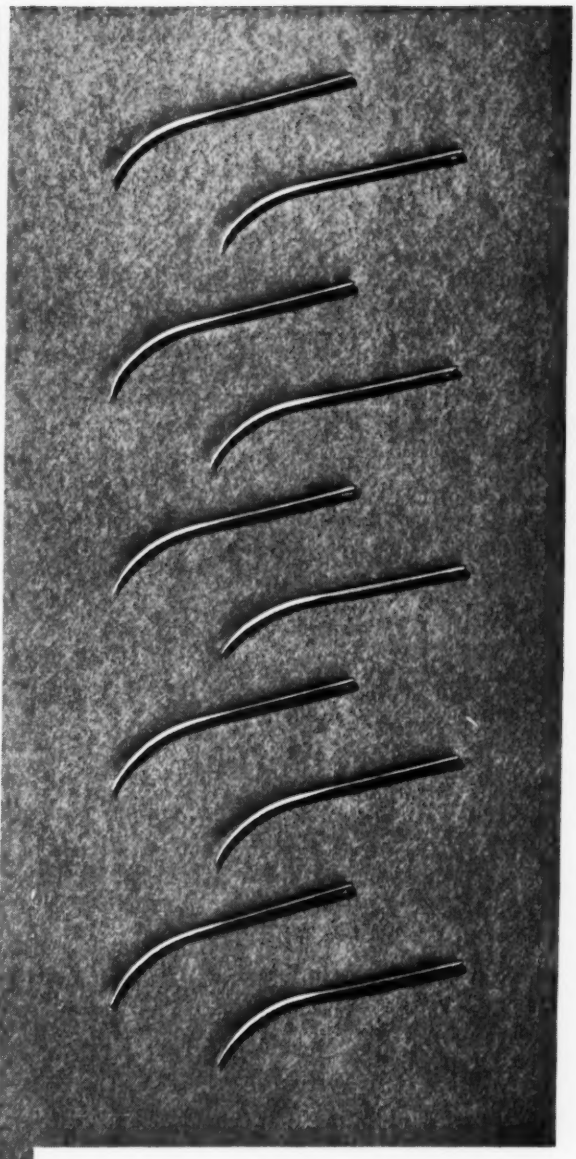

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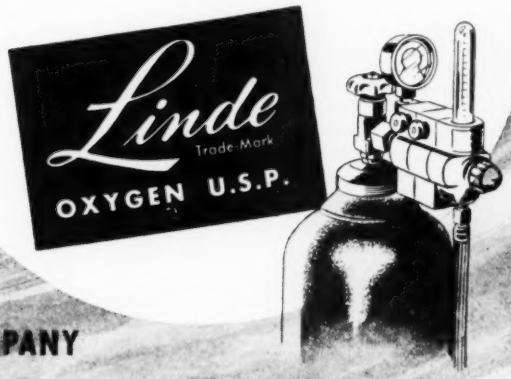

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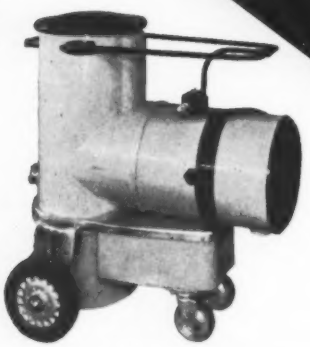

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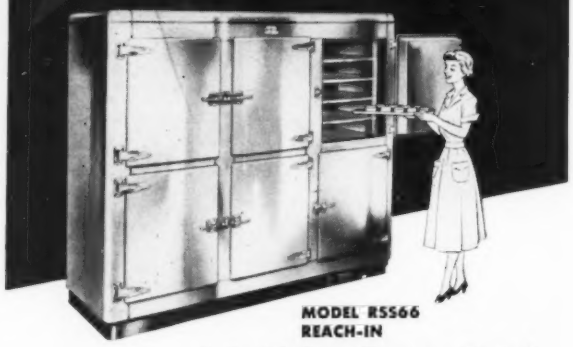

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Because of their year-after-year durability, trouble-free performance and economical operation, HERRICK Stainless Steel Refrigerators actually cost less in the long run than many "inexpensive" units. HERRICK gives you more value per dollar, too, in easier cleaning and convenience to the chef. For complete food conditioning at lowest per-year-of-service cost, HERRICK is your best refrigerator buy. Write today for the name of your nearest HERRICK supplier.

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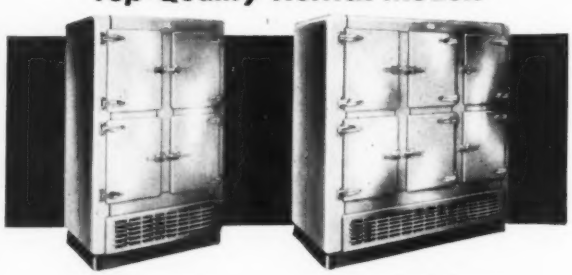

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Hexachlorophene in Dial Liquid Antiseptic Soap assures faster scrub-ups, greater protection!

Here is a superior product that saves time, offers greater protection in operating rooms – Dial Liquid Antiseptic Soap with Hexachlorophene!

Tests have shown that the surgeon who uses a soap containing Hexachlorophene removes in only 3 minutes *more* skin bacteria than he does with a conventional 10-minute scrub-up followed by a germicidal rinse!

Dial Liquid Antiseptic Soap was created by Armour to give your surgeons this greater safety in a mild soap. Both the 20% and Concentrate Dial contain 5% Hexachlorophene, based on soap content—your assurance of truly germicidal protection. See that your surgeons have the best – Dial Liquid Antiseptic Soap, available in 55-gallon drums.

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Hexachlorophene is available for nurses and patients in DIAL's famous bar soap. DIAL, even though it contains Hexachlorophene, *costs your hospital no more* than ordinary soaps. It is available in ½ and 2½-ounce sizes, both *wrapped* and *unwrapped*, and ¾ and 1-ounce sizes, unwrapped only. Order DIAL from your Armour salesman today!

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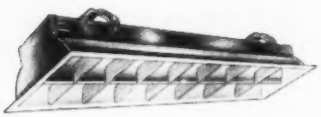
What's New for Hospitals

MARCH 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 252. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Brightness Reduced with Unchanged Efficiency



A new important lighting development is announced with the Para-Louver. With its use, lengthwise brightness of a parabolic troffer is considerably reduced without changing the efficiency of the lighting fixture. A louver has been designed with the parabola divided into segments and projected onto a flat surface. A second series of parabolas with an axis to reflect the light upwards joins the larger segments, thus all light is controlled. The new development permits installation of the Day-Brite Alzak Aluminum Parabolic Troffer at any angle with complete comfort and efficient lighting. **Day-Brite Lighting, Incorporated, 16 N. 9th St., St. Louis 1, Mo. (Key No. 509)**

Repeated Autoclaving Possible With Patapar Steribags

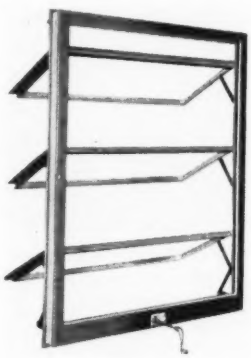
Buck Steribags, made of Patapar parchment paper, have high wet strength and can be autoclaved again and again. Patapar does not disintegrate in contact with water or steam but has an enormous water-vapor transmission rate. Hence the Steribags are economical in use as well as effective. The re-usable Steribags are available in sizes for catheters, syringes, gloves, instruments and dressings. **A. J. Buck & Son, 1515 E. North Ave., Baltimore 13, Md. (Key No. 510)**

Unusual Ventilation Problems Handled by New Sets

Consisting of fan, motor and drive in a single package, the new Westinghouse ventilating sets are designed to handle unusual ventilation and exhaust problems. The all-purpose units are available in two series, covering a wide range of capacities. The "900" series is direct-drive from fan to motor, in six different sizes. The twelve sizes of the "1000" series feature an adjustable V-belt drive. All units are powered by standard Westinghouse motors. Weatherproof covers are available for outdoor mounting. Direction of discharge may be adjusted for ease of installation. **Westinghouse Electric Corp., 200 Readville St., Hyde Park, Boston 36, Mass. (Key No. 511)**

Aluminum Awning Window Provides Weather Protection

A new Lupton aluminum awning window has been designed especially for construction where horizontal lines are emphasized. It permits greater control of ventilation through open-out, awning-type sash. The windows afford



enough protection to be left open even when it is raining. Another advantage is offered in cleaning. The awning windows can be cleaned on both sides from the inside, simplifying the process and eliminating any danger from outside cleaning. When screens or storm sash are needed they fit on the inside.

A centrally operated control bar delivers equal power to both jambs for easy opening and closing and ensures a tight seal around each sash. The complete vinyl plastic weather stripping on the inside contact of the frame is protected from weather damage. The operating mechanism is completely concealed in the window frame and provides finger-tip control. **Michael Flynn Mfg. Co., 700 E. Godfrey Ave., Philadelphia 24, Pa. (Key No. 512)**

(Continued on page 222)

"Floor-Knight" Is new Twin Tank Mopping Outfit

Previously available only as a single tank outfit, the new Floor-Knight Model 816 is a twin tank outfit with a new type of side and gear cover completely enclosing the wringer gearing and adding to mop life. The unit is designed to accommodate smaller sized mops from 8 to 16 ounces and incorporates all of the features of other Geerpres twin outfits. Water is squeezed down and out by means of pressure bars spun at both ends. Mops slide easily and naturally, without tearing, in and out of the wringer and are protected against contact with moving parts. **Geerpres Wringer, Inc., Muskegon, Mich. (Key No. 513)**

Parents Carry Infant Home in Disposable Bassinet

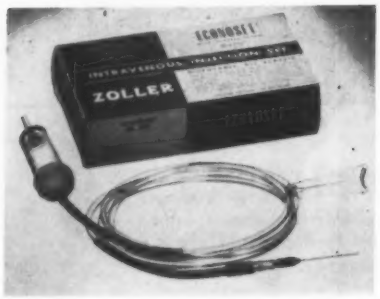
Considerable public good will can be built up with the new Disposable Bassinet now available. Each newborn infant is placed in its own Disposable Bassinet. When taken from the hospital the infant is carried out in the same bassinet. The attractive, light weight, durable unit can continue to be used in the home and the parents are assured that there is no possibility of infection from earlier use.

Disposable Bassinets are inexpensive and save time in scrub-up and disinfection. Parents can be charged for the units, and there is profit for the hospital even when the charge is modest. The new bassinet is made of rigid, water-resisiting Flute-wood stock finished in white with attractive designs in blue or pink. The bassinets are of one-piece construction and can be stored flat. They

are assembled in a minimum of time and fit practically any bassinet stand. **The Presco Company, 218 Fifth Ave., W., Hendersonville, N.C. (Key No. 514)**

What's New . . .

Disposable Needle in IV Set for One-Time Use



The Econoset is the name given to a completely disposable intravenous set which includes a detachable administration needle. The unit is shipped sterile, pyrogen-free, non-toxic and ready for immediate use. The attached needle is sharp, sterile, burr-free, clean and also ready for use. Both the set and the needle are designed to be discarded after one administration. The low price makes it possible to use these economically and the work of sharpening, cleaning and sterilizing needles is eliminated. A similar unit, without the needle, is available as the Sterilset. **Zoller Chemical Corporation, 3440 Wilshire Blvd., Los Angeles 5, Calif. (Key No. 515)**

Heavy-Duty Cleaner Incorporates Three Units

The BWD-18 is a heavy-duty wet-dry vacuum cleaner that incorporates three versatile cleaning units. The 1 h.p. universal type by-pass motor may be removed easily for use as a portable vacuum to reach difficult areas. It can also be used as a blower for cleaning motors and machinery. The portable unit, known as the Porta-Vac, and the blower can be used with a full line of attachments for special jobs. The motor is polished aluminum and the tank on the new model has a special alkali and rust resistant baked enamel finish. **Clarke Sanding Machine Co., Muskegon, Mich. (Key No. 516)**

Vinyl Sheet for Wall Covering

A new embossed plastic wall covering has been developed with colors that cannot be touched or damaged. Known as Kalitex, the new sheet is offered in a burlap weave pattern. Since the color is applied to the back of the transparent vinyl resin sheeting, it cannot be changed or faded by constant cleaning.

Kalitex provides a low cost permanent treatment when applied over plaster or other firm backing surface. It is offered in blue-green, gray-green, wine, tan, sunshine yellow, gray and light coral. **United States Plywood Corp., 55 West 44th St., New York 36. (Key No. 517)**

Movable Steel Partitions for Laboratories

Designed and engineered specifically for the needs of laboratories, VMP Mobil-Lab-Walls incorporate internally housed utilities. The six inch thick movable steel partitions have post and panel construction providing access to and support for mechanical and electrical services. Up to 20 feet of services and utilities, in one section, may be removed and repaired without disturbing work in an adjacent laboratory. All shelving and wall cabinets may be installed, changed or removed quickly and easily.

The new partitions incorporate major advances in laboratory design and are the result of considerable research and development. They permit flexibility in the planning, construction and management of laboratories and also result in savings in plumbing, electrical, mechanical and other phases of laboratory installations. **Virginia Metal Products, Inc., Orange, Va. (Key No. 518)**

Compact Door Closer With Variable Speed

A small, compact door closing device has been introduced which offers any speed of door closing desired. It is operated by means of a compression spring in conjunction with a hydraulic piston and two adjusting valves. The door can be closed as fast as two seconds or as slow as two minutes without slamming. Any individual with an ordinary screw driver can make the necessary adjustment by merely making two or three turns on the adjusting screw.

The device is easily installed. A bracket is screwed on the door and the closer and arm quickly slipped into place. A smaller bracket holds the end of the arm to the door frame. The door closer is completely reversible to fit right and left hand doors and is adaptable to an almost unlimited variety of doors and frames. The new Schlage T-500 Door Closer has undergone severe tests in the laboratory and in actual use, with excellent results. **Schlage Lock Co., Dept. MH, 2201 Bay Shore Blvd., San Francisco 19, Calif. (Key No. 519)**

(Continued on page 226)

"Private Line" Systems in Automatic Telephones

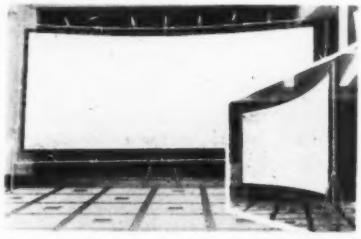
A new and complete line of intercommunicating systems has been introduced under the name Connecticut "Private Line" systems. The line of automatic switchboards and telephones is the most complete the company has ever offered and provides facilities for those needing as little as two telephones up to those requiring thousands of telephone lines. A low cost two to five line system for small installations is introduced as the Connecticut Direct-A-Call which can be installed by a maintenance man.

Both the Private line and the Direct-A-Call system have advanced engineering providing many features usually found only in other systems at extra cost. The unique design and construction of the completely automatic systems permits simplified installation and maintenance. Telephones for both systems will be made of super-tough Hercocel molded plastic. **Connecticut Telephone & Electric Corp., Meriden, Conn. (Key No. 520)**

Portable Curvex Unit for Wide Screen Viewing

The new Radiant Curvex Screen is a portable unit developed for wide screen projeciton of 16 mm motion pictures. The new screens will be available in sizes from five feet to 20 feet wide. The picture is projected on the screen with an anamorphic or squeeze lens that shows an image which approximates the wide expanse of normal vision, giving the viewer a sense of being in the picture, without the necessity for wearing special glasses.

The new screen is made with a highly reflective silver fabric and is two and one-half times as wide as it is high. The aluminum framework curves the fabric to help increase the illusion of depth and to give better reflected light distribution throughout the area of observation. Uniform brilliance from all viewing angles is claimed for the tightly laced, specially treated fabric which can also be used for three dimensional projection. When not in use the fabric may be rolled and the light weight frame folded for quick storage in a metal case



which makes the unit easy to carry. **Radiant Manufacturing Corp., Dept. MH, 2627 W. Roosevelt, Chicago 8. (Key No. 521)**

to Mr. Purchasing Agent

FOR PROFITING FROM A NEW IDEA...

he switched to...

ANGELICA "TY-FREE"* PATIENT GOWNS

and reduced linen room repairs

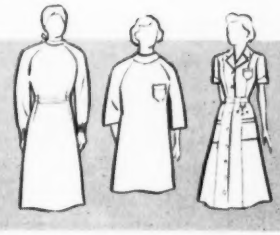
It's a smart P. A. who recognizes the merits of a new idea in hospital apparel. New Angelica "Ty-Free" Patient Gowns have many features that mean big savings:

(1) Indestructible cloth buttons eliminate ties, cut linen room repairs, save nurses' time. (2) Overlapping back tabs form perfect, comfortable neck closure. (3) Roomy sleeve openings permit easy access for examination. (4) No bulging back ties to lie on. (5) Re-inforced neckline and front yoke for longer wear.

All Angelica Hospital Apparel is available for immediate delivery. Call your Angelica representative today.

*T. M. Reg.

Complete Line of Uniforms for:
DIETARY
MAINTENANCE
OPERATING ROOM
HOUSEKEEPING
PATIENTS
NURSING



Angelica® UNIFORMS

1427 Olive, St. Louis 3 • 107 W. 48th, New York 36 • 177 N. Michigan, Chicago 1 • 110 W. 11th, Los Angeles 15

The first truly elastic bandage the dryer won't "kill"

Even in the autoclave, new TENSOR with Heat-Resistant live rubber threads won't lose its stretch

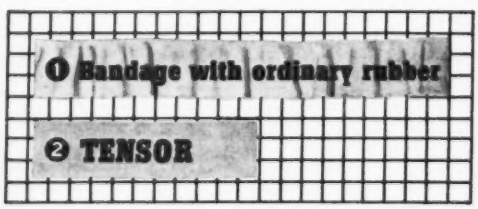
Here's the first truly elastic bandage that doesn't require *special handling* at the laundry to protect its stretch . . . the first elastic bandage that heat won't hurt.

The Heat-Resistant live rubber threads in new Tensor can stand temperatures up to 280° F. with no appreciable loss of elasticity. They are virtually unaffected by the high heat of commercial or hospital drying equipment.

The result: Tensor lasts much longer . . . and costs less to use. Even after many, many launderings, you can still rely on Tensor to provide the steady, easy-to-control pressure that made it famous as the first truly elastic bandage.

Have you ordered new Tensor yet? It's available (at no increase in cost) in hospital bulk put-ups. Why not specify Tensor next time you stock up on medical supplies?

COMPARE THESE ELASTIC BANDAGES



❶ One-foot length of bandage made with ordinary rubber is stretched after high temperature drying—and stays stretched. Its elasticity "died" in the dryer.

❷ But one-foot length of heat-resistant Tensor snaps back to its original length, even after prolonged exposure to near scorching heat of commercial dryer.

New TENSOR® ELASTIC BANDAGE

Woven with Heat-Resistant live rubber threads

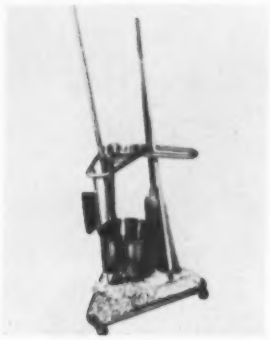
BAUER & BLACK

Division of The Kendall Co.
309 West Jackson Blvd., Chicago 6, Ill.


cyclo-flush
Electromatically Supervises
Bedpan Technique.....
For further information
Write to Dept. HA-3
AMERICAN STERILIZER COMPANY
Erie, Pennsylvania

What's New . . .

Efficient Handling of Housekeeping Tools



A triangular shaped cart that fits neatly into any corner and holds most of the tools needed for quick clean-up is now available. It is light and easy to maneuver, yet large enough to have space for mops, broom and bucket. A convenient stainless steel tray provides space for soaps, powders and cleaning rags.

Made of 1 inch steel tubing, the Tomac Housekeeping Cart has gray enamel chipproof Surgalum finish with a stainless steel tray 10½ by 8 by 8 inches in size, 2¼ inches deep. The overall height is 31½ inches and the bottom shelf is 22½ by 18½ inches in size. The cart has a 2 inch rubber swivel with ball bearing casters. **American Hospital Supply Corp., Evanston, Ill. (Key No. 522)**

Curity Incontinent Pad Has Plastic Protector

A plastic bottom sheet is used on the new Curity Incontinent Pad to ensure complete protection for linens and mattresses. Repeated tests failed to show leakage or even dampness on the bottom of the pad after prolonged wetting. Drainage is absorbed and retained in the pad, and the plastic bottom keeps it there.

The pads have increased thickness of absorbent filler for maximum capacity. A new Skintex top sheet gives added patient comfort and permits drainage to penetrate immediately to the absorbent inner layers. Skintex is strong and tear-resistant and has the feel of skin, whether it is wet or dry. The plastic bottom sheet is so made that it does not slide from under the patient. **Bauer & Black, Dept. MH, 309 W. Jackson Blvd., Chicago 6. (Key No. 523)**

Discoloring of Peeled Potatoes Prevented by Preserver

A new formula is used in the Don Potato Preserver to keep peeled or cut potatoes from discoloring. Potatoes are simply dipped in a solution of one tablespoon to a gallon of water, allowed to remain a few minutes, drained, air-dried and stored away. They keep fresh and white for days with proper refrigeration. Dry storage avoids sogginess and retains the natural, crisp, fresh flavor of the potatoes and makes them cook faster and taste better even when prepared in advance. The preserver can also be used effectively on fruits and other vegetables without impairing flavor or quality. **Edward Don & Company, 2201 S. La Salle St., Chicago 16. (Key No. 524)**

Improved Sanitation With No-Contact Urinal

The Hygia is a new no-contact urinal designed for use in women's washrooms to promote cleanliness and better sanitary conditions. It is available as a wall-hung unit and in two pedestal-type models with either flush valve or tank. With three models to choose from, the Hygia can be adapted to practically every washroom floor plan for new installations or remodeling.

The units have either concealed or exposed flush valves with siphon jet flushing action. Concealed rim jets clean the elongated bowl swiftly and quietly.

The rounded edges and vitreous china surfaces make the Hygia easy to keep clean. It has approximately the same dimensions as many siphon jet closets and can be used as replacement without elaborate changes when washrooms are being modernized. **Kohler Co., Dept. MH, Kohler, Wis. (Key No. 525)**

Electronic Deodorizer Has Long Lasting Lamp

A new electronic ozone deodorizer has been introduced under the name Klenz-Aire. It is an attractive chrome wall fixture of smart design with an ozone lamp and other non-moving parts. The unit is complete, ready for instant use, and is 6½ inches high. With continuous 24 hour use the life of the deodorizing ozone lamp is estimated at approximately 4000 hours. The reflector plate design makes the light effective as a soft night light. The fixture is compact, portable and light in weight and is available in single, twin or three lamp unit, depending upon the odor problem. **General Manufacturing & Distributing Co., Quincy, Mich. (Key No. 526)**

(Continued on page 230)

Long Wear Promised for Nylon Pillowcases

Nylon pillowcases are now available for hospital use. They are easily laundered and require no ironing, thus saving one operation in the laundry. In addition, these cases of 70 denier du Pont nylon will wear indefinitely, even with hospital use, resulting in a long term saving. **Webb Manufacturing Company, 2936 N. 4th St., Philadelphia 33, Pa. (Key No. 527)**

Streamlined Design in "Baker Boy" Oven

The new 1954 "Baker Boy" series ovens have been streamlined in design and engineering. The chain drive transfers an even flow of power from the drive to the reel, with no jerky stops and starts. A new development makes it easy to adjust the chain after years of service. Enclosed chain drive and shaft bearings are outside the heat zone. Bearings inside and in the heat zone require no oiling.

The ovens have rounded corners, porcelain panels and polished aluminum trim, top and bottom, with attractive appearance and ease of cleaning. Doors are light weight aluminum with frames of heavy gauge stainless steel. Standard equipment includes a built-in shelf indicator. The ovens are available for gas or electric heating systems. **Despatch Oven Co., Dept. MH, 619 S.E. 8th St., Minneapolis 14, Minn. (Key No. 528)**

Non-Clogging Dispenser for Powdered Soap

Powdered soap is accurately delivered, with a minimum of waste, with the new non-clogging DeWitt Soapserver. It is attractive in appearance, made of steel with chrome finish and has a sturdy hinged lid. The dispensing mechanism is protected from water by splashing or condensation and the spiral spring agitator for dispensing prevents packing of contents. The dispenser is easily loaded through large perforations which elimi-

nate the need for locks or keys, yet protect against pilferage. **The DeWitt Company, Dept. MH, 603 Addison St., Chicago 13. (Key No. 529)**

Choose STANDARD for effective pest control

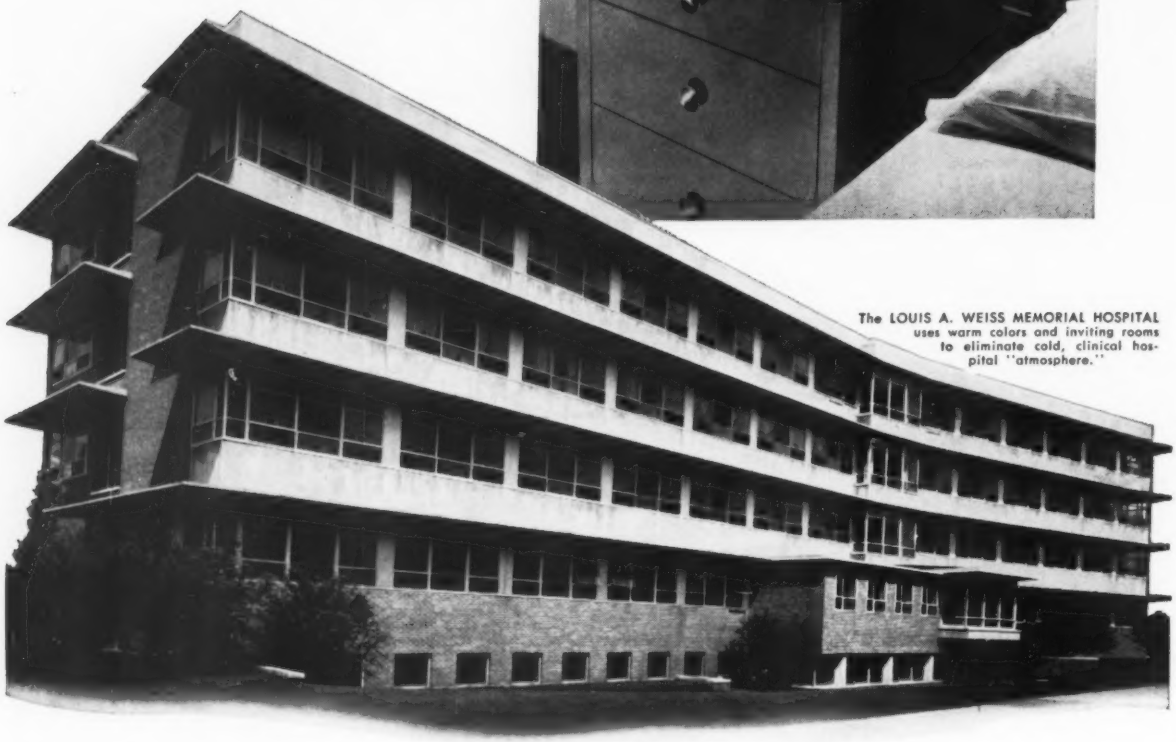
STANDARD Aerosol Insect Killer—Contains pyrethrins and DDT for fast positive killing action against flies, mosquitoes, and other pests. **STANDARD MOTHBAN Moth Killer**—Protects woolens two ways: kills and mothproofs. Prevents damage from moths, carpet beetles in *all* stages. **STANDARD Pressur-Pak Plant Spray**—Kills pesky plant insects (aphids, red spiders, etc.). Use on all plants both outside and indoors. Standard's new aerosol insecticides are always ready for instant use. Why not order a case of twelve? **STANDARD Insect Spray with DDT**—Kills on contact. Residual effect lasts for weeks preventing re-infestation. Available in quantities to fit your needs: one gallon to full barrel. **STANDARD Roach and Ant Spray**—Combines DDT and chlordane for effective control of hard-to-kill roaches, ants, waterbugs, spiders and silverfish. Kills by direct spray; residual effect lasts for weeks. Easy, economical to use; gallon and five gallon cans.

Standard insecticides (and floor maintenance products) are available for immediate delivery from over 3900 warehouses in the Midwest. That means there's a convenient source of supply near you. Order now. If you have a special problem in insect control (or in floor maintenance), you can get expert advice from your nearest Standard Oil sales office, listed below.

STANDARD OIL COMPANY
(Indiana)

Chicago • Decatur • Peoria • Joliet • Evansville
Indianapolis • South Bend • Detroit • Grand Rapids • Saginaw • Duluth • Mankato • Minneapolis • Green Bay • La Crosse • Milwaukee
Des Moines • Mason City • St. Louis • Kansas City • Wichita • Omaha • Denver • Cheyenne
Billings • Huron • Fargo

designed
for today's advanced standards . . .



The LOUIS A. WEISS MEMORIAL HOSPITAL uses warm colors and inviting rooms to eliminate cold, clinical hospital "atmosphere."

NEW LOUIS A. WEISS MEMORIAL HOSPITAL
. . . nearly 100% equipped with VOLLRATH stainless steel HOSPITAL WARE

THIS 3 million dollar general hospital, Chicago's newest hospital located on the northside lakefront, incorporates many innovations in construction, materials and equipment — joining ideas of the future with advancements of today.

Modern hospitals like Weiss Memorial demand durability and functional good looks from all their equipment. This is particularly true in the selection of clinical utensils.

That's why Weiss management specified long-lasting Vollrath stainless steel Ware. This heavy-gauge stainless steel equipment is sturdily built to stand up under the rugged wear of daily use. Quality materials and fabrication give you long range economy and minimum replacement. What's more, seamless, crevice-free construction makes Vollrath Ware easy-to-clean for everlasting brightness . . . certain to conform to rigid sanitary standards.

• • •

See your dealer today. Ask about the advantages of standardizing on Vollrath stainless steel Hospital Ware.

SINCE 1874 — The Vollrath Co. — SHEBOYGAN WISCONSIN

THE VOLLRATH COMPANY
Sheboygan • Wisconsin

Exclusive manufacturers of Vollrath Ware for 80 years — since 1874.

Sales Offices and Display Rooms:
New York • Chicago • Los Angeles

LOW COST
PLUS SURE

O.R.

APPROVAL

MAKES WILTEX AND WILCO LATEX GLOVES THE "NATURAL CHOICE"

The Wilson
RUBBER COMPANY
THE WORLD'S LARGEST EXCLUSIVE MANUFACTURERS OF RUBBER GLOVES
CANTON · OHIO

What's New . . .

Sturdy, Utilitarian Top on Overbed Table

The Tan Linen plastic top on the new Hard Overbed Table is divided into three sections and has plastic protective edging. The vanity mirror in the center of the top reverses automatically, making the table equally useful from either side of the bed. The top crank is easily operated in this modern functional table, and it rolls out of the way so as not to strike the wall. The double telescoping uprights give added rigidity and strength to the table which has rubber bumpers on all four feet. The four casters make it easily moved. **Hard Manufacturing Co., 117 Tonawanda St., Buffalo 7, N.Y. (Key No. 530)**

Cold Cathode Ballast Operates Four or Six Lamps

A new 4 lamp cold cathode ballast circuit has been developed which operates four LP or HP FLA Certified cold cathode lamps. It is made in two types, for operating lamps at 100 or 120 MA. Also in production is a new cold cathode ballast to operate six lamps at 100 or 120 MP. Lamps operating on the new 100 MA 4 lamp ballast produce 2230 lumens per lamp and those on the 120 MA produce 2450 lumens. **Cold Cathode Equipment Co., 2349 E. Nine Mile Rd., Hazel Park, Mich. (Key No. 531)**

Quick Coffee Brewer Fits Neck of Container

Designed to fit into the neck of the AerVoid carrier, the new AerVoid Portable Quick Coffee Brewer simplifies the making and serving of coffee. It provides a quick, economical, time-saving way to brew up to ten gallons of coffee ready for transporting to patients, to cafeteria or wherever quantities of coffee are served. It is a light, portable unit which requires no installation or replacement, except coffee bags, and makes it possible to produce fresh coffee quickly, any place where there is hot water. It is made of stainless steel, is placed in the top of the AerVoid Carrier, and coffee is made in minimum time. **Vacuum Can Company, 19 S. Hoyne Ave., Chicago 12. (Key No. 532)**

Dual-Purpose Hand Truck Serves as Step Ladder

A new combination hand truck and step ladder unit has been developed which facilitates moving or storing supplies, maintenance work and other tasks in institutions. Known as the Step-Truk, the unit fulfills all conventional usages of a hand truck and a ladder. It has specially designed curved crossbars and a solid nose plate, making it effective as a hand truck. When used as a ladder, it leans on the nose plate which serves as a firm base, providing a safe platform. **Fairbanks Company, 395 Lafayette St., New York 3. (Key No. 533)**

(Continued on page 234)

DEXTER DIAPERS

Machine Packed in Osnaburg Bags

DDs COST LESS ON THE JOB THAN ANY OTHER — FOR SERVICE INSTITUTIONS

36 DOZ. PER BAG

DIRECT FROM FACTORY TO YOU!

You will have to use "Dexter Diapers" to believe them. They go on and off baby in a jiffy—without folding, save half the changing time in your nursery. In your laundry they are easier to count, wash, dry, wrap, need no folding, take up less room, last longer, cut your laundry costs right in half. They are nationally advertised in 26 publications as an institution diaper. Ask your Diaper Service Company or write direct to Dexter Diaper Factory for sample and free booklet with facts about diapering written by a famous physician.

DEXTER DIAPER FACTORY, HOUSTON 8, TEXAS

Balmaseptic

TRUE DEODORANT LIQUID SOAP

CONTAINS HEXACHLOROPHENE (G-11)

. . . the antiseptic agent used in modern surgical soaps. Reduces skin bacterial count as much as 95%

BALMASEPTIC'S time-saving and surgically cleansing properties provide "round the clock freshness" when used for wash-up or shower. But that's only part of the story, for BALMASEPTIC is made of premium quality soap ingredients, scented delightfully like the most expensive cake soaps . . . *and its price is well within your soap budget!*

Let your Dolge Service Man demonstrate Balmaseptic's remarkable value. Dispensing equipment available.

FOR FREE SANITARY SURVEY of your premises consult your DOLGE SERVICE MAN

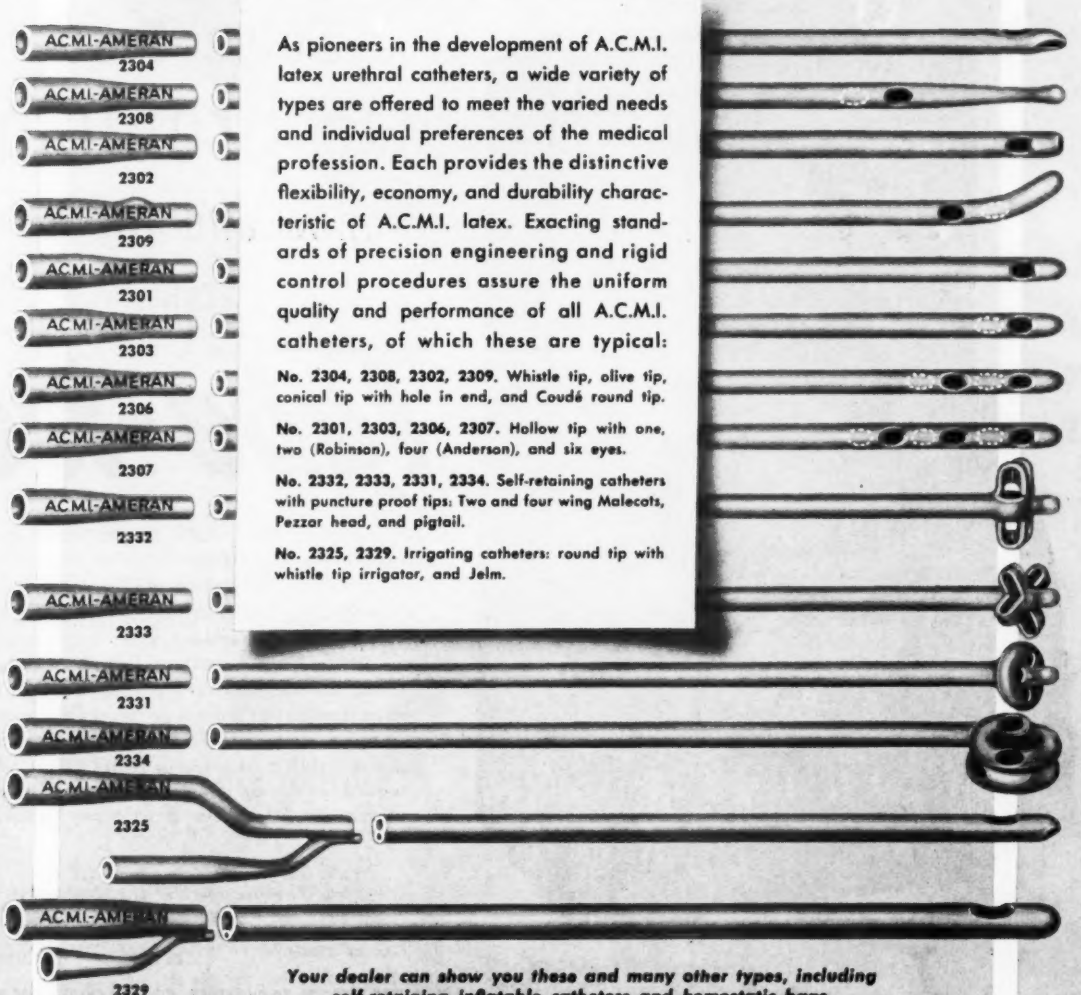
dependable DOLGE

WESTPORT, CONNECTICUT

For unsurpassed quality . . .

LATEX URETHRAL CATHETERS

by A.C.M.I.—to meet varied requirements



As pioneers in the development of A.C.M.I. latex urethral catheters, a wide variety of types are offered to meet the varied needs and individual preferences of the medical profession. Each provides the distinctive flexibility, economy, and durability characteristic of A.C.M.I. latex. Exacting standards of precision engineering and rigid control procedures assure the uniform quality and performance of all A.C.M.I. catheters, of which these are typical:

No. 2304, 2308, 2302, 2309. Whistle tip, olive tip, conical tip with hole in end, and Coudé round tip.

No. 2301, 2303, 2306, 2307. Hollow tip with one, two (Robinson), four (Anderson), and six eyes.

No. 2332, 2333, 2331, 2334. Self-retaining catheters with puncture proof tips: Two and four wing Malecots, Pezzar head, and pigtail.

No. 2325, 2329. Irrigating catheters: round tip with whistle tip irrigator, and Jelm.

Your dealer can show you these and many other types, including self-retaining inflatable catheters and hemostatic bags.

FREDERICK J. WALLACE, *President*

American Cystoscope Makers, Inc.

1241 LAFAYETTE AVENUE **NEW YORK 59, N. Y.**

Too little-too late

too much-too soon

Solve that ice problem once and for all with Tube-Ice*

Hotels, restaurants, clubs, hospitals and other institutions no longer have to depend on guesswork or "lucky hunches" when trying to estimate their daily ice needs. That problem is eliminated once and for all with the installation of the Vogt Automatic Tube-Ice Machine which provides "Ice-on-tap" . . . to be drawn on as needed . . . from a never ending source. Complete details on Vogt Tube-Ice Machines, now available in sizes ranging from 2,000 pounds per day up to any capacity, will be sent on request. Write for descriptive Bulletins.

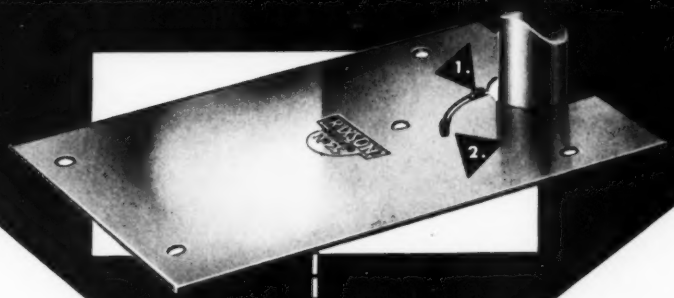
**Tube-Ice, produced by the Vogt Automatic Tube-Ice Machine is a clear, hard ice of superior quality. Either cylinder or crushed ice may be had at the flick of a switch!*

HENRY VOGT MACHINE CO. · LOUISVILLE, KY.

BRANCH OFFICES: New York, Philadelphia, Chicago, Cleveland, St. Louis, Dallas, Charleston, W. Va.

Vogt Automatic TUBE-ICE MACHINE

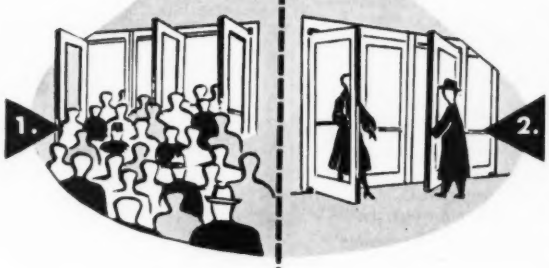
now...
a *SELECTIVE* hold-open



for RIXSON floor type closers

When selector lever is set at spindle, automatic hold-open will function.

The selector lever places the automatic hold-open in contact position so that it engages and holds the door whenever it is opened to the degree at which the hold-open is set. The door is released by a firm pull.



When selector lever is away from spindle, device functions only as door closer.

When the selector lever is swung away from the spindle, the automatic hold-open is disengaged. When the lever is in this position the device functions only as a door closer.

SELECTIVE means you have a hold-open *only when you need it.*

The new RIXSON floor type closers with *built-in selective hold-open* gives you complete door control to suit varying conditions. They are ideal on entrance doors where heavy crowds pass through on occasions . . . such as dismissal time or after a show or lecture. At these times the selector lever is set for hold-open. The door is swung open and holds. The crowds will move through much faster, and wear and tear on the door and jamb will be avoided. The hold-open is also practical for use in keeping doors open in summer weather.

At such times when only a normal flow of people pass through the doors, the automatic hold-open can be disengaged and the RIXSON closer will serve only to bring the door to a quiet, gentle close after each opening.

The selector lever does not hold the door open . . . it merely places the automatic hold-open mechanism in contact position so that it engages and holds the door, whenever it is opened to the degree at which the hold-open is set. Degree of hold-open predetermined and factory set.

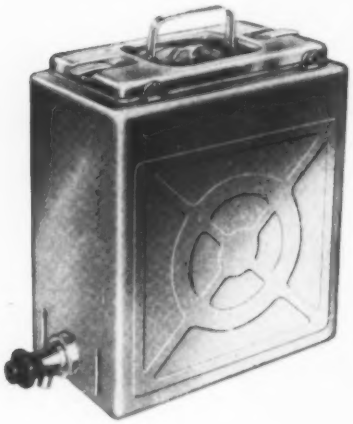
write for full details and templates

THE OSCAR C. RIXSON COMPANY

4450 west carroll avenue • chicago 24, illinois

What's New . . .

Rectangular Jug for Heated Beverages



The No. 1320 Rectangular Beverage Jug is an electrically heated unit with two gallon capacity. It has a thermostatic control which protects the unit from burning out in case all liquids are drawn out of the container. It is designed for use in serving hot beverages but hot soups can also be served. The unit plugs into a 110 volt circuit and keeps liquids at 185 degrees.

The jug can also be used for serving cold liquids and ice cream if desired. For this purpose a stainless steel well is attached to the lid which permits the use of dry or wet ice as a refrigerant without diluting the contents. **Landers Frary & Clark, New Britain, Conn. (Key No. 534)**

Speed and Efficiency In Deep Fat Fryers

The new Speedster French Fryers have been introduced for quick and economical deep fat frying. The new Mighty-Mite Electric Fryer produces 1200 French Fries per hour with only 10 pounds of fat. The large frying area with efficient fat depth is augmented with efficient heat transfer. It has a lift-out heat unit for easy cleaning and because of its size can be placed in any convenient location and simply plugged into any electric outlet.

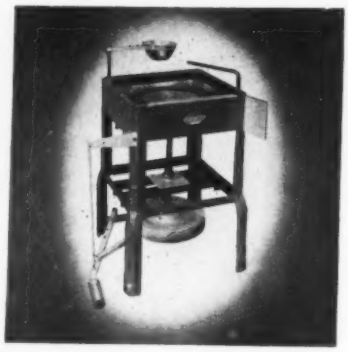
The Speedster Champion Electric Fryer produces 380 two ounce servings of french fried potatoes per hour in only 26 pounds of fat. It is designed to preheat to 350 degrees in 4½ minutes. The recovery and frying cycle time is only 4 minutes. Choice of one, two or three baskets is offered for complete frying versatility. Ruggedly built for constant heavy-duty performance, the fryer has frying-cover, a filter-fat crumb tray, 5-way insulation and adjustable feet. **Miller & Carrell Mfg. Co., Dept. MH, 1051 Santa Fe Drive, Denver 4, Colo. (Key No. 535)**

(Continued on page 238)

Treadle Wheel for Vocational and Art Training

Adjustable in height, the new Craftool Treadle Wheel will have many uses in occupational therapy departments. The foot treadle can be used for either left or right action and has three speeds. The heavy cast aluminum head is reversible. The 75 pound balanced fly wheel is mounted on a one inch shaft and runs on two self-aligning ball bearings.

A removable plastic tray, 20 by 20 by 4½ inches in size, is easily cleaned and a natural drain is provided. The tension bolted steel construction prac-



tically eliminates vibration in the machine and all fittings are oxidized against rust. **Craftools, Inc., 401 Broadway, New York 13. (Key No. 536)**

THE IMPROVEMENT OF PATIENT CARE

A Study at Harper Hospital

by Marion Wright, R.N., M.S.
Associate Director Harper Hospital, Detroit

Foreword by E. Dwight Barnett, M.D.
Director, Institute of Administrative Medicine, Columbia University, N. Y.

Published in co-operation with and under the sponsorship of the American Hospital Association, George Bugbee, Executive Director

A report of the study made at Harper Hospital, where a determined and dynamic administration decided to do something about a critical situation.

It has important implications for all who share management responsibilities in the hospitals of today.

Miss Wright presents her material as a *report* and not as a *lecture*. She tells you what was done and how. She makes no attempt to tell other administrators what they *should* do. She explains how the business community sent many of its leaders to contribute their skills in helping Harper Hospital and its neighbors solve a serious problem.

Must reading for every member of the administrative staff.

To be published soon. Price $5.50

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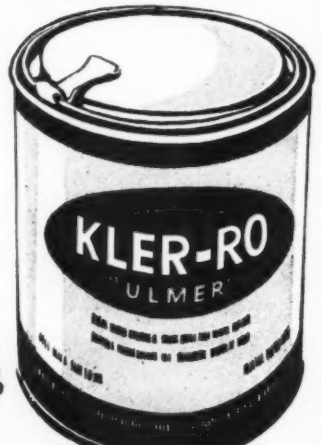

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a single 2-lb. can gives you 42 gal. of full strength detergent solution.

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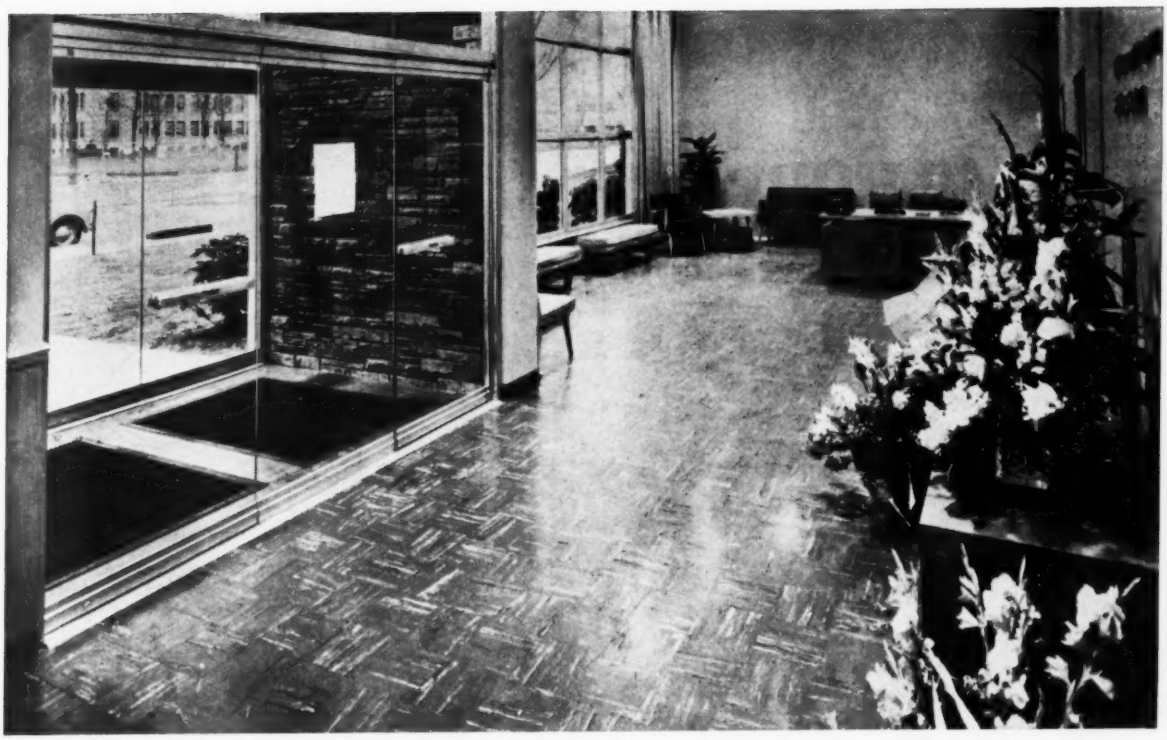

Enter: Colorful Flexachrome!

EXIT: DRABNESS AND WEAR!

When beautiful Flexachrome* Vinyl Plastic-Asbestos Tile enters the picture the entire atmosphere of a reception room *perks up!*

Flexachrome's sharp, brilliant colors *radiate* cheerfulness! And there are 28 of these beauties to choose from, colors that never lose their bloom because they go through from surface to surface.

Sanitation and cleaning are easy as pie with Flexachrome because this material has such a tight, closely-textured surface. Daily sweeping and periodic washing are all that is necessary. *No* waxing needed unless a high gloss finish is desired.

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Flexachrome is completely *greaseproof*, too . . . which makes it ideal for use in all food areas.

And as for *wearing ability*, you can always count on this beautiful, durable material to hold its own, year after year, against the most punishing traffic.

So, if you have a flooring problem, get in touch with your TILE-TEX* Contractor today. He's listed in the classified pages of your phone book . . . and you'll find his recommendation invaluable.

Or write us:

THE TILE-TEX DIVISION, The Flintkote Company, 1234 McKinley Street, Chicago Heights, Illinois

Tile-Tex—Pioneer Division, The Flintkote Company, P. O. Box 2218, Terminal Annex, Los Angeles 54, California

The Flintkote Company of Canada, Ltd., 30th Street, Long Branch, Toronto, Canada

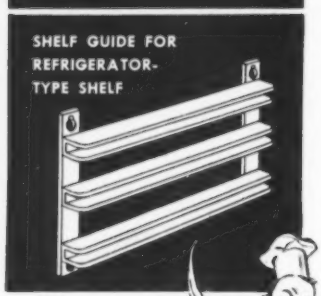
*REG. U.S. PAT. OFF.

TILE-TEX... *Floors of Lasting Beauty*

Puts your kitchen on wheels!

Model No. 9518

Ideal Mealmobile Model No. 9018 and Model No. 9518 provide both hot and cold compartments in the same unit. Model No. 9524 provides hot and cold capacity for 24 persons. Any model can be fitted with trays, drawers, shelves and tray guides as desired. Cold compartments can be fitted with cold hold-over plates.



Still more saving of labor and time is brought to hospital feeding operations by the Ideal Mealmobile—a new, unique Ideal Tray Conveyor. This new Ideal Unit delivers trays and plates of hot and cold food to the bedside with all the fresh, appetizing qualities of servings just out of oven or range.

The new Ideal Mealmobile provides service for 18 or 24 persons. It holds removable and interchangeable pull-type warming drawers or refrigerator-type shelves; each affording space for two nine inch plates and four side dishes or other utensils of equal size. Adjustable, removable, and interchangeable tray guides are supplied in two designs, one for pull-out-type drawers and serving trays and the other for refrigerator-type shelves. Tray guides accommodate all sizes of trays up to 15¼" x 20½". Trays are carried firmly without sliding or tilting.

The Ideal Mealmobile is made entirely of polished stainless steel. All tray guides are removable leaving the entire interior open for cleaning. The conveyor can be cleaned by steam or any other method as there is no exposed wiring. All corners are rounded. Heated section is fully insulated with Fiberglas. The Ideal Mealmobile moves easily on 8 in. ball bearing rubber tired wheels. Temperature control is fully automatic. A Robertshaw thermostat assures absolute accuracy. The Ideal Mealmobile is built in 3 models, affording a wide range of performance, and service capacity for 18 to 24 persons.

Ideal
HOSPITAL EQUIPMENT
Found in Foremost Hospitals

Distributed by A. S. Aloe Company, St. Louis 3, Missouri; Colson Corporation, Elyria, Ohio; Colson Equipment & Supply, Los Angeles, Calif.; Dillon Scale & Equipment Co., Dallas, Texas; Canadian Fairbanks Morse, Ltd.; Montreal, Canada.

HIA HOSPITAL INDUSTRIES ASSOCIATION

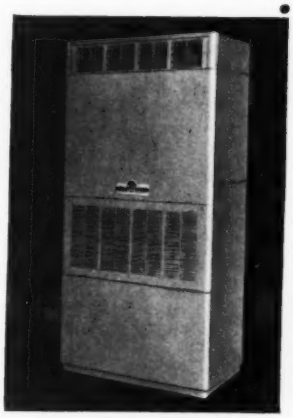
WRITE FOR CATALOG AND COMPLETE DATA

MADE ONLY BY THE Swartzbaugh MANUFACTURING COMPANY
ESTABLISHED IN 1884
TOLEDO 6, OHIO

these facts will help you get the most from your air conditioning dollars

The following six engineering facts **(and 31 more your York Distributor can show you) demonstrate why so many establishments have discovered—to their profit—that YORKAIRE CONDITIONERS deliver the *right kind* of air conditioning over a very, very long life!**

CHECK THESE ENGINEERING FACTS!	READ THESE ADVANTAGES YOU GAIN!
● Entire Cooling Circuit Hermetically Sealed	Eliminates expensive fall "shut-down" and spring "start-up."
● Full 5-Year Protection Plan	If hermetic circuit proves defective due to faulty materials or workmanship, York will repair defective parts or replace entire circuit without cost to you.
● Steel "Skyscraper" Construction	Protects internal parts against harmful "twisting" encountered when moving ordinary conditioners.
● Staggered-Tube-and-Corrugated-Fin Construction of Cooling Coils	Tumbles *all* the air into contact with cooling surfaces, providing 30% more effective cooling.
● Capillary-Tube Feed	Ingenious one-piece tube replaces complicated valves commonly used.
● Adjustable Air Flow	Grilles may be adjusted vertically and horizontally. York cools without chilling!



Famous Yorkaire "Packaged" Air Conditioner. Complete line from 1½ horsepower up.

Prepare for summer with the *right kind* of air conditioning. Call your York Distributor for early delivery. He's listed in your Classified Telephone Directory. Or write to...

YORK CORPORATION York **YORK, PA.**

air conditioning by york

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885

What's Now . . .

Economy Floor Machine Available in Four Models

All of the features included in the Speedboy Deluxe floor maintenance machines are included in the new utility model known as the Speedboy Special. This is an economy machine which is available in four models, the smallest having a 12 inch brush spread. The new model has Silent-Flo drive and other Advance features for efficient operation. **Advance Floor Machine Co., Dept. MH, 2613 Fourth St., S.E., Minneapolis 14, Minn. (Key No. 537)**

"Durapress" Parfait Added to Glass Line

The line of attractive, economical and durable glass dishes known as "Durapress" now includes a parfait. This matches the line of sherbets, sundaes and sodas available in the line. The parfait has a heavy glass base, is modern in shape and has an easy-to-clean design. It is strong and durable and is low in cost. The new parfait, as the other items in this attractive glass line, makes it possible to offer more attractive food service. **Libby Glass, Dept. MH, Toledo 1, Ohio. (Key No. 538)**

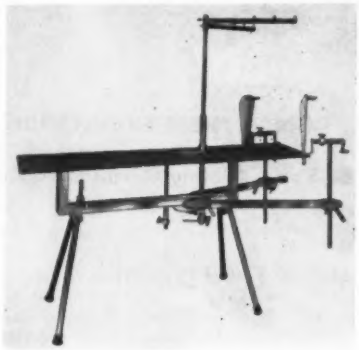
Elastic Bandage Is Self-Adherent

A cotton-nylon bandage, with elastic nylon warp threads, is being introduced as the Presso-Nylex. It is said to have high elasticity and compression, to be self-adherent, and to restore lost elasticity by heating, without laundering. The new Nylex bandage is being brought out in white only. **Medical Fabrics Co., Inc., Dept. MH, 10 Mill St., Paterson 1, N.J. (Key No. 539)**

Virgin Fracture Table Is Lightweight Portable Unit

Technical advice and research in developing the Virgin Fracture Table were provided by Dr. Herbert W. Virgin, Jr. of Miami, Florida. The versatile table is streamlined, efficient, simple to operate and portable. The patient is held comfortably and firmly in any desired position and the table permits full access to the operative area. With accessories, the Virgin Fracture Table can be used effectively for hip nailing.

The table is sturdily built with demountable legs, telescoping sections and plastic finished top. It can be completely disassembled into a relatively small package for carrying and can be taken down or reassembled in a minimum of time. The table is economical in price, simple and effective in use, and can be used in the surgery, the emergency room, clinics, offices, and in children's hospitals as it is readily adapted for use with children. **Gilbert Hyde Chick Company, 821 75th Avenue, Oakland 21, Calif. (Key No. 540)**



(Continued on page 242)

Compare . . . and you'll decide AMERICAN

Model AWC-801 Chrome Upholstered Non-Folding Wheel Chair With Adjustable Leg Rests.

Here is the wheel chair that has no equal . . . Since 1919, AMERICAN's engineering staff has sought ways to produce the ideal modern hospital type wheel chair—the true "thoroughbred" in appearance and performance!

American

"AMERICA'S FINEST WHEEL CHAIRS" . . . SINCE 1919

For 20 page 1953 catalog and dealers' names, write to . . . . .

AMERICAN WHEEL CHAIR CO., INC.
3451 West Fifth Ave., Dept. M, Chicago 24, Illinois

How's this for savings?

with

WEBB PILLOWCASES

70 denier duPont Nylon...

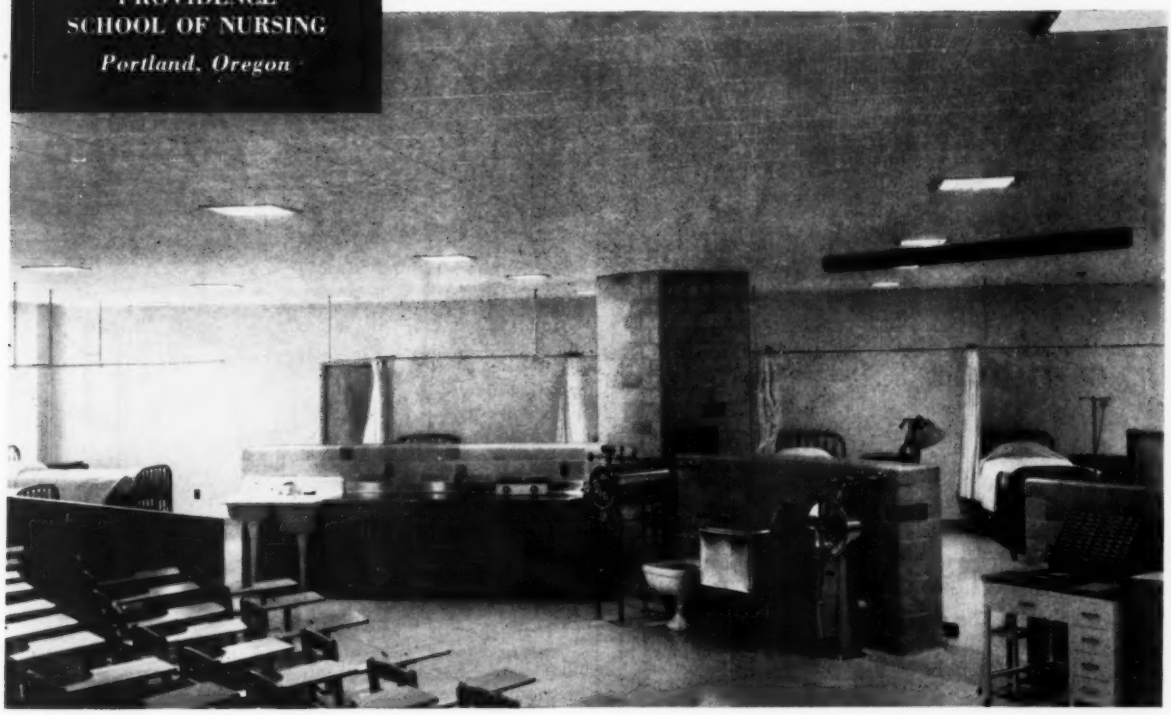
These pillowcases should actually outlast your present ones *10 to 1*. Naturally, they're priced higher! But consider these offsetting advantages: little laundering—no ironing—quick drying—lower inventory—and much longer wear. Other supplies include shower curtains, linens, laundry hampers, bags, bathrugs, lab uniforms.

Write for information and prices.

WEBB MANUFACTURING COMPANY
2936 N. 4th Street, Philadelphia 33, Pa.

PROVIDENCE
SCHOOL OF NURSING
Portland, Oregon

Architect: **John Maloney**
Acoustical Contractor: **Arteraft Linoleum & Shade Co.**



Equipped to reproduce hospital conditions, this nursing arts laboratory is the finest of its type on the Pacific Coast. Its ceilings of Cushiontone are easy to clean, meet strict sanitary standards.

New ceilings give students and staff undisturbed quiet

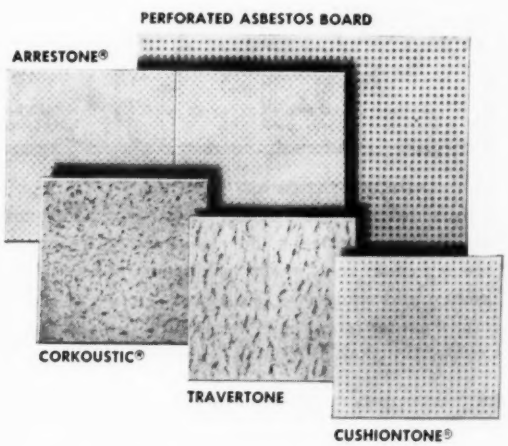
Work in a nursing school requires a good deal of concentration on the part of both students and instructors. To provide the necessary quiet in the new Providence School of Nursing, sound-absorbing ceilings of Armstrong's Cushiontone have been installed.

Armstrong's Cushiontone is a perforated wood fiber acoustical material that absorbs as much as 75% of the noise that strikes its surface. Cushiontone is finished with two coats of white paint. It can be washed or repainted without loss of acoustical efficiency.

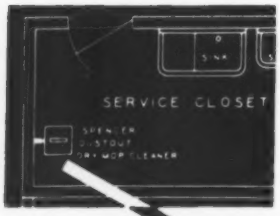
Low in initial cost, Cushiontone is also economical to install. Whether used in new construction or remodeling, Cushiontone goes up quickly and easily by nailing, cementing, or mechanical suspension.

You can get full details on Cushiontone and Armstrong's other sound-conditioning materials from your local Armstrong Acoustical Contractor. For the free booklet, "How to Select an Acoustical Material," write to Armstrong Cork Company, 4203 Union Street, Lancaster, Pennsylvania.

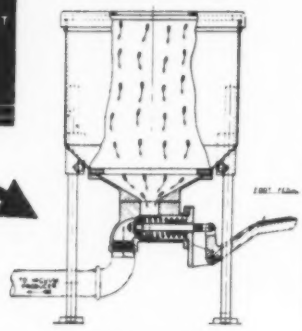
Undisturbed quiet is a valuable asset to the nursing school library. Here, low-cost acoustical ceilings of Armstrong's Cushiontone soak up noise and help to promote a more restful atmosphere for reading or studying.



ARMSTRONG'S ACOUSTICAL MATERIALS



Cabinet 15" square with vacuum slot in cover



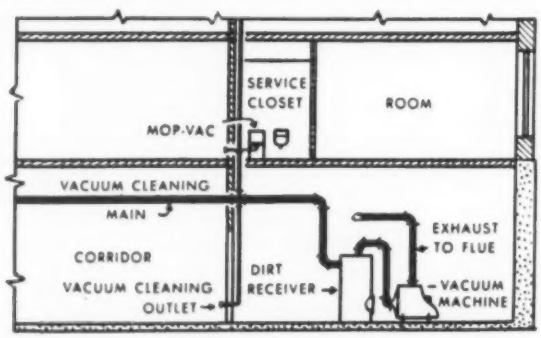
Cleans Dry-Mops in a minute

THE SPENCER MOP-VAC

. . . ANYWHERE

The only sanitary way to clean a dry-mop or dust cloth is to let Spencer Vacuum clean it for you. Just pass the mop over a vacuum slot attached to the Spencer System at a baseboard, flush with the floor, or on the top of a cabinet in a service closet. The strands are immediately agitated by the violent rush of air. All dust goes down enclosed pipes to the basement. Fewer steps, more frequent cleaning—and no possibility of germ-laden dust being spread over the hospital.

SIX TYPES Cabinet units are made in the open type illustrated above and in high and low enclosed cabinets. Special attachments are available for baseboard or flush floor mounting and for Spencer Portable Cleaners.



with **SPENCER STATIONARY VACUUM SYSTEM**: The sketch above shows how the Spencer Vacuum producer and dirt separator are located in the basement and connected to vacuum fixtures on all floors for cleaning of floors, bedding, furniture and equipment of all kinds.

The Spencer Mop-Vac is described in Bulletin No. 138-C and the Stationary System in Bulletin No. 33.

THE SPENCER TURBINE COMPANY • HARTFORD 6, CONNECTICUT

SPENCER HARTFORD

450-C

SAVE YOUR FLOORS

from SCRATCHING, MARRING, GOUGING

Any floor keeps its good looks far longer when you equip hospital beds, laundry hampers, screens, bedside tables and service carts with Bassick "Diamond-Arrow" casters or rubber-cushion glides.

That means lower floor maintenance costs. It also means nurses and attendants have an easier time because these Bassick casters make anything that's mobile roll easily, safely and quietly.

"DIAMOND-ARROW CASTERS"

Easy-rolling casters with soft rubber tread that can't harm floors. Double ball-bearing construction for faster swivelling. Electrically conductive wheels supplied where needed. Stems and adapters for every type of equipment. (Caster shown has Bassick rubber expanding adapter for tight grip in bed legs.)

RUBBER-CUSHION GLIDES

Smooth-sliding and quiet. Broad flat base of highly polished, hardened steel glides easily over any surface. Live-rubber cushion absorbs noise and bumps. Easily attached to wooden furniture legs by simply driving in nail. Special adapters furnished for use with metal tubing legs.

THE BASSICK COMPANY, Bridgeport 2, Conn.
In Canada: Belleville, Ont.

Check Hospital Purchasing File for other Bassick floor-protection equipment

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A DIVISION OF STEWART SW WARNER

MAKING MORE KINDS OF CASTERS . . . MAKING CASTERS DO MORE

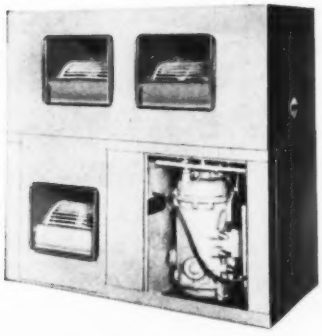
75 YEARS OF CASTER LEADERSHIP

THE TRULY MODERN HOSPITAL MUST BE AIR CONDITIONED

Is water for air conditioning a problem?

get CHRYSLER AIRTEMP Waterless Air Conditioning!

Conventional air conditioning for hospitals uses lots of water, and in some places water is scarce. Or it may be too expensive or too hard or corrosive. But now Chrysler Airtemp advanced engineering has made modern air conditioning practical for any hospital *—anywhere!* Chrysler Airtemp *Air-Cooled* Air Conditioning uses only electricity—no water whatsoever. Because no plumbing is needed, it costs less to install. And it's a compact package which takes up so little space!



"Packaged" Air-Cooled Air Conditioners, which operate without water, and Water-Cooled types in nine models, 2 through 15 H.P. Other Chrysler Airtemp products for all systems of air conditioning — a complete line to suit every requirement.

Whether you install Chrysler Airtemp Air-Cooled or Water-Cooled "Packaged" Air Conditioning . . . you can depend on a refreshingly comfortable atmosphere to help patients rest easier, feel better and recover faster. With Chrysler Airtemp Air Conditioning in your hospital, doctors and nurses will work more efficiently, experience less fatigue. And with windows always closed, with only filtered-clean air circulating, it will be so much easier to keep your hospital "hospital-clean." Send coupon now for complete details!

Guaranteed by Good Housekeeping

CHRYSLER AIRTEMP

heating · air conditioning for homes, business, industry

Airtemp Division, Chrysler Corporation, Dayton 1, Ohio

Airtemp Division, Chrysler Corporation MH-3-54
P.O. Box 1037, Dayton 1, Ohio
I'd like to know more about Chrysler Airtemp Air Conditioning.

Name_____

Address_____

City_____ Zone____ State_____

What's New . . .

Group Blood Tests Quickly Made With Lancet Set

"Floating" action, described as the result of complete freedom of the blade within the blade unit, is offered in a new automatic blood lancet set. It is said to make group blood tests handled more quickly, easily and safely, and to permit taking blood samples with virtually no pain to the patient.

Known as the Steri-Lance, the set consists of an automatic handle and six or eighteen stainless steel blade units in a small metal box. The snap-type handle contains a recoil spring which is adjustable for force and depth of puncture. The blade unit can be quickly changed with one hand and the blade is not touched by the fingers. The stainless steel blades are easily removed for cleaning, and are replaceable. The bottom of the case is perforated for easy sterilization of the contents. **Propper Manufacturing Co., Inc., 10-34 44th Drive, Long Island City 1, N.Y. (Key No. 541)**

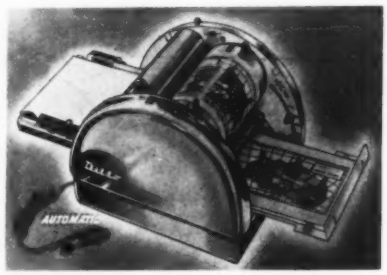
Instant Communication with Two-Phone Intercom

The Duo-Com is a simplified two-phone system for instant natural voice communication. There is no dialing, switchboard or other accessories as contact between the phones is made simply by lifting the receiver and depressing a button. The system is easily installed, operated and maintained and will work for many months on a single six-volt battery. The system saves time and steps and frees telephone lines for outside calls. **RCA Victor Division, Radio Corporation of America, Dept. MH, Camden, N.J. (Key No. 542)**

High Quality Duplicator at Popular Price

The new Ditto D-11 is an automatic electric direct process duplicator at a popular price. It is ruggedly constructed and incorporates many features found in the higher priced Ditto machines. The high quality power drive and power clutch ensure quality performance. The machine can be used for hand feed, if desired, through the use of a simple, tripping operation handle.

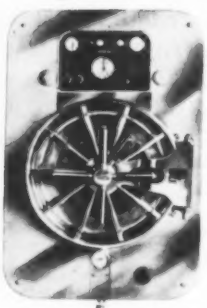
The Ditto Direct Process Duplicating principle is used in the D-11, eliminating the need for stencils, type or mats. It is designed to reproduce two copies per second of anything typed, written, drawn or printed through duplicating carbon, in as many as five colors in one operation. Copies can be made on any weight paper from 16 pound to heavy card stock, and in any size up to 8½ by 14 inches. Features of the new model include a disappearing receiving tray, reversible feed tray facilitating handling of long and short sheets, quick shift paper guide for instant adjustments for various sized



forms, swinging feed rollers and stainless steel parts to prevent corrosion. The D-11 has gun metal gray finish. **Ditto Incorporated, Dept. MH, 2257 W. Harrison St., Chicago 12. (Key No. 543)**

(Continued on page 244)

a series of . . .
AETNA SCIENTIFIC
'points to ponder'



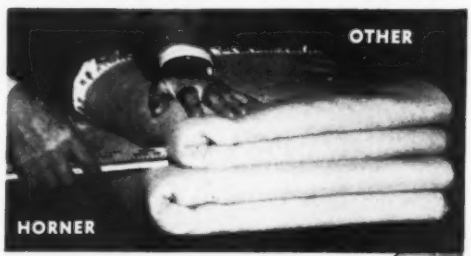
• STERILMATIC CONTROL
• Aetna Dressing and Instrument Sterilizers provide:
- Positive Sterilization through a full time cycle
- Cannot short-cut this vitally important operation
- Easily operated with fully automatic controls
- Time cycle adjustable to individual requirements
- Mounted on recessed or exposed sterilizers

A full line of rugged, monel, heavy duty, pressure sterilizers, designed and built to the strictest specifications, are available for laboratory, hospital, institutional, commercial and industrial applications.

AETNA SCIENTIFIC COMPANY
SECOND & SPRING ST., EVERETT 49, MASS., U.S.A.
New catalog of Aetna Sterilizers, Water Stills, Autoclaves and Hospital Equipment free upon request by letter.

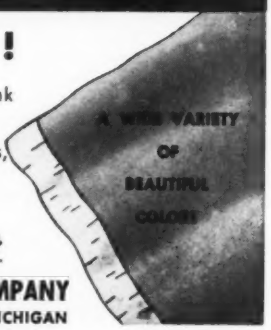
HORNER
ALL WOOL
Anti-shrink
HOSPITAL BLANKET

LETS YOU SEE THE DIFFERENCE!

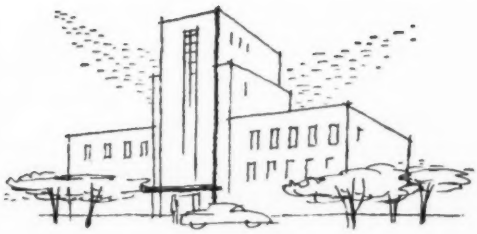


America's Leading Anti-shrink process blanket . . . preferred by foremost hospitals, hotels, and colleges throughout the country.

SHRINKAGE IS REDUCED UP TO 83% UNDER NORMAL LAUNDRY CARE.



HORNER WOOLEN MILLS COMPANY
EATON RAPIDS 1, MICHIGAN



Modern hospitals aid patient recovery with a thermostat in every room

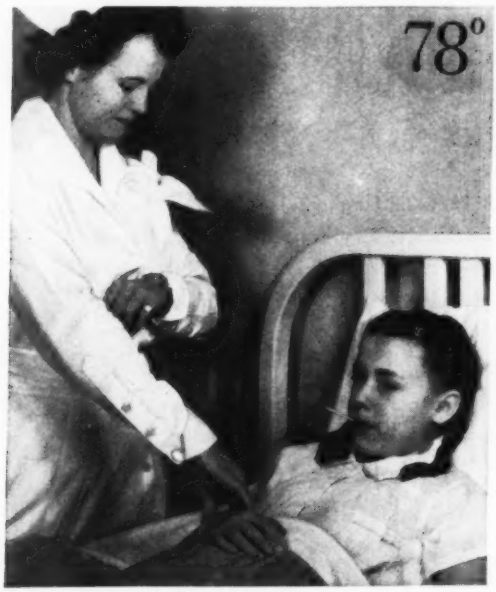
DOCTORS in many modern hospitals today speed patient recovery by prescribing *exactly correct* room temperatures. But this medical practice is possible *only when you have a thermostat in every room.*

No other method can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room. That's why modern hospitals install Honeywell Individual Room Temperature Control.

You'll want to investigate Individual Room Temperature Control if you plan to modernize your hospital or build a new one. Of course, the most economical time to install this system is when the hospital is being built . . . installations usually cost only between ½ and 1% of the expenditure per bed. And new methods make installations in existing hospitals practical, too.

For complete details on Honeywell Controls for your hospital, call your local Honeywell office . . . or write Honeywell, Dept. MH-3-23, 351 East Ohio Street, Chicago 11, Illinois.

In Room 309, this patient is convalescing after surgery, and his doctor prescribed a room temperature of 70°. This can be accurately set because the hospital has Honeywell Individual Room Thermostats.



In Room 409, this little girl has passed a pneumonia crisis and her physician feels that to help her recovery, she needs a temperature of 78°—possible only with Individual Room Temperature Control.

Mark of a modern hospital!

You get *all* these features *only* in this specially designed Honeywell Hospital Thermostat:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***Magnified numerals*** make readings easy to see.
- ***New Speed-Set control knob*** is camouflaged against tampering.
- ***Air-operated;*** requires no electrical connections.
- ***Lint-Seal*** insures trouble-free, dependable operation.

MINNEAPOLIS **Honeywell**

H HONEYWELL

First in Controls

104 offices across the nation

What's New . . .

Automatic Transformer Keeps Electrosurgical Unit Steady

Power is kept constant at 115 volts, even when incoming line voltage varies, with the automatic transformer incorporated into the new Model C264 Electrosurgical Unit. The transformer operates so as to produce maximum cutting and coagulating for efficiency. Power output on the vacuum tube cutting current end of the spark gap coagulating current has been substantially increased in the new model without damage to instruments or excessive destruction of tissue. Oscillator tubes utilizing both waves of the alternating current cycle assure full wave rectification. **American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59. (Key No. 544)**

Two Machines Added to Floor Maintenance Line

Two new machines have been added to the Holt Whirlwind line for floor maintenance. The new Holt Senior Whirlwind 14 and 16 machines will polish, wax, scrub, steel wool and shampoo. The fully adjustable handle on the new machines pushes to upright position for easy storage. A toe latch releases the handle which may be adjusted and tightened at any desired working position. The machine is moved by placing the handle in the storage position, then tilting until the wheels touch the floor.

Other features of the new machines include safety switch handgrip which stops the machine when released; static eliminator wire in the polishing brush; non-marking rubber bumper and cable; quiet-running gear reduction unit, and quickly interchanged attachments to convert the machine for any maintenance job. **Holt Manufacturing Co., Dept. MH, 669 20th St., Oakland 12, Calif. (Key No. 545)**

Freeline Library Table Has No Apron

The new Freeline series of library tables features a completely new design. It has no apron so that only the solid hardwood top shows on any of the four sides. There are six tables in the new line, varying in size from 3 to 10 feet long and from 24 to 42 inches wide. There is also a round table 4 feet 2 inches in diameter. Top thickness varies from 1¼ to 1½ inches.

The new design utilizes modern structural engineering methods to obtain maximum utility. The legs are machine turned to eliminate sharp edges that might chip or splinter. They are tapered into stainless steel ferrules for protection against scuffing, and splayed for maximum strength and stability. The undertable construction, indicated in the illustration, is such that the legs, ribs and keel are anchored directly to the top. Thus there is nothing to interfere with seating or armchairs. The new tables

provide practical, comfortable, sturdy equipment for the library. **John E. Sjöström Company, Dept. MH, 1717 N. Tenth St., Philadelphia 22, Pa. (Key No. 546)**

(Continued on page 246)

Something Missing?

GENNETT CLEANERS UTILITY CART

BUILT TO CARRY THE LOAD
this sturdily constructed cart makes happier help more efficient cleaning.

Made in 3 sizes—
Large U2; Small HU2;
Maids MU2.

Model U-2
$56.00 list
F.O.B. Factory

Gennett and Sons, Inc.
1 Main St. Telephone 2-2151
Richmond, Indiana

QUALITY . . . the towering background behind every Berbecker Needle

BERBECKER Surgeons' Needles are precision products of English needle crafters. The renown of their skill is international. The depth of their experience is measured in generations.

To such a background is due the high, uniform quality—the consummate dependability—of Berbecker Surgeons' Needles.

Sold Only By Dealers

BERBECKER
SURGEONS' NEEDLES
Made in England for the Surgeons and Hospitals of America
Julius Berbecker & Sons, Inc., 15 E. 26th St., New York 10, N. Y.

Check these wonderful RUSCO features...

Such Complete Protection!

There's never a worry about drafts, rain, snow or wind with Rusco. Magicpanel® ventilation control gives year 'round rainproof, draft-free ventilation.

So Quiet!

Rusco Windows provide highly effective insulation against street noises. Glass panels raise and lower smoothly and quietly in felt-lined slides.

So Easy to Operate!

No sticking, no "freezing," no jamming with Rusco Windows. Panels slide easily in a cushion of felt, lock in desired position with positive spring-bolt action. Glass panels removable from *inside*, and interchangeable, which simplifies cleaning and any broken glass repairs.

So Trouble-Free!

Rusco Windows are triple-protected against weather — finished like a car body, with baked-on outdoor enamel. They have no sash cords, weights, balances or chains to get out of order. More than 11,000,000 installations testify to their serviceability.

FOR NEW CONSTRUCTION

Specify: THE RUSCO PRIME WINDOW

A completely pre-assembled window unit containing glass, screen, weatherstripping, insulating sash (optional) and wood or metal surround. Comes fully assembled, finish-painted, ready to install. Makes big savings in time and labor.

FOR MODERNIZING EXISTING BUILDINGS

Specify: RUSCO SELF-STORING COMBINATION WINDOWS

Installed without any alteration to present windows. Completely weatherproof window openings. Provide rainproof, draft-free, filtered-screen ventilation in every kind of weather. The world's largest-selling combination window — over 11,000,000 already installed.

RUSCO ALL-METAL WINDOWS, DOORS, PORCH ENCLOSURES
ADJUSTABLE VENETIAN AWNINGS • DOOR & TERRACE CANOPIES

For illustrated literature and name of nearest Rusco dealer, write **THE F. C. RUSSELL COMPANY** Dept. 6-MH34, Cleveland 1, Ohio
In Canada: Toronto 13, Ontario

What's New . . .

Plastic Filling Material for Lung Collapse

Developed in Denmark for partial lung collapse in treatment of pulmonary tuberculosis is a new plastic filling material known as Polystan Plombe. It is a new type of high-molecular plastic which is said to be unaffected by body fluids, can be cut and molded into any shape required to fit into the collapsed area, and causes no foreign body reaction. Blood vessels and connective tissues grow into it, fixing it in place, and it does not shrink or interfere with x-ray pictures.

Plombe filling is left permanently in place in the lung to promote healing and prevent the spread of the lesion. It provides selective collapse and avoids deformity and complications. The new material is available in several convenient forms and consistencies. **Lakeside Laboratories, 1707 E. North Ave., Milwaukee 2, Wis. (Key No. 547)**

Unitized Lighting System Is Flexible and Economical

Astra-Lite is a new series of fluorescent lighting fixtures providing an exceptionally flexible and economical method of illuminating corridors, offices and other institutional facilities. The system consists of two primary units which can be combined into a variety of ceiling patterns that will provide effective lighting for any type of area. The units can be arranged in squares, rectangles, continuous straight runs, crosses and many other shapes. In most cases the system can be installed without new wiring or outlets. The fixture is available with or without louvers, in bi-pin or slimline styles, with plastic or steel side panels, and is finished in triple-sprayed baked enamel. **Metalcraft Products Co., Inc., Dept. MH, Mascher & Lippincott Sts., Philadelphia 33, Pa. (Key No. 548)**

Refrigeration Unit for Surgical Procedures

Local refrigeration prior to amputation in cases of limb infection has been found to simplify surgical procedures. An electrically-operated refrigeration unit has been developed especially for this purpose. The refrigeration unit is mounted within a small, portable, soundproof cabinet which can be placed under the patient's bed. An insulated tubing leads to a small freezing unit which rests on the bed and into which the foot or hand is placed. An automatic relay device attached to the refrigerator maintains constant temperature and there is an easily adjusted control for the selection of the desired temperature. The small opening through which the foot or hand is introduced is closed with a heavy felt pad.

Temperatures are maintained without fuss or messiness, and the patient is comfortable and has relative freedom of movement in the bed. With the new method a limb can be properly refrigerated in two to three hours, according to the manufacturer. **Webber Manufacturing Co., Inc., Dept. 182, 2740 Madison Ave., Indianapolis 3, Ind. (Key No. 549)**

(Continued on page 248)

How do you select your BLANKETS?

ST. MARYS OFFERS
Sleeping Luxury
AT LOWEST COST PER YEAR OF SERVICE RENDERED

St. Marys

For the better part of a century, St. Marys Blankets have been proving and re-proving their remarkable economy under daily use. Soft, luxurious, beautiful—they add to your reputation for thoughtful service and comfort.

St. Marys Blankets are *certified washable* by the American Institute of Laundering. Available in a variety of sizes and in colors to match or harmonize with your room decor. Regular or special bindings, permanently stamped names or crests.

Write for name of supplier in your territory

ST. MARYS BLANKETS • ST. MARYS, OHIO

"They last . . . and last . . . and last"

Stimulate FUND RAISING

Style B
Solid cast bronze or aluminum tablet. Raised letters in bold relief contrasting with stippled oxidized background.

Style P
Raised letter cast bronze room plaque with double line border. Available in all sizes.

Plaques & nameplates in bronze, aluminum or plastic have been proved the ideal, dignified and most effective way to raise funds for hospitals.

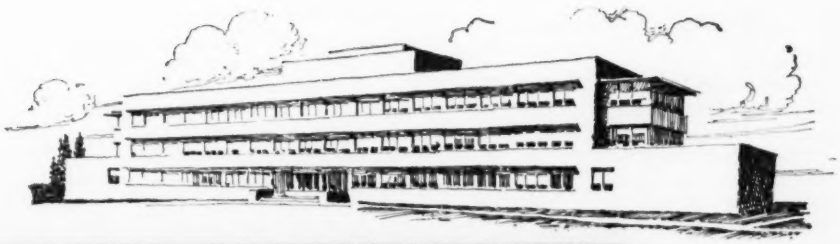
By acknowledging contributions in this permanent manner you encourage future donors. Why not write us now for illustrations and prices. You'll be pleased by this economical and attractive way to give permanent recognition.

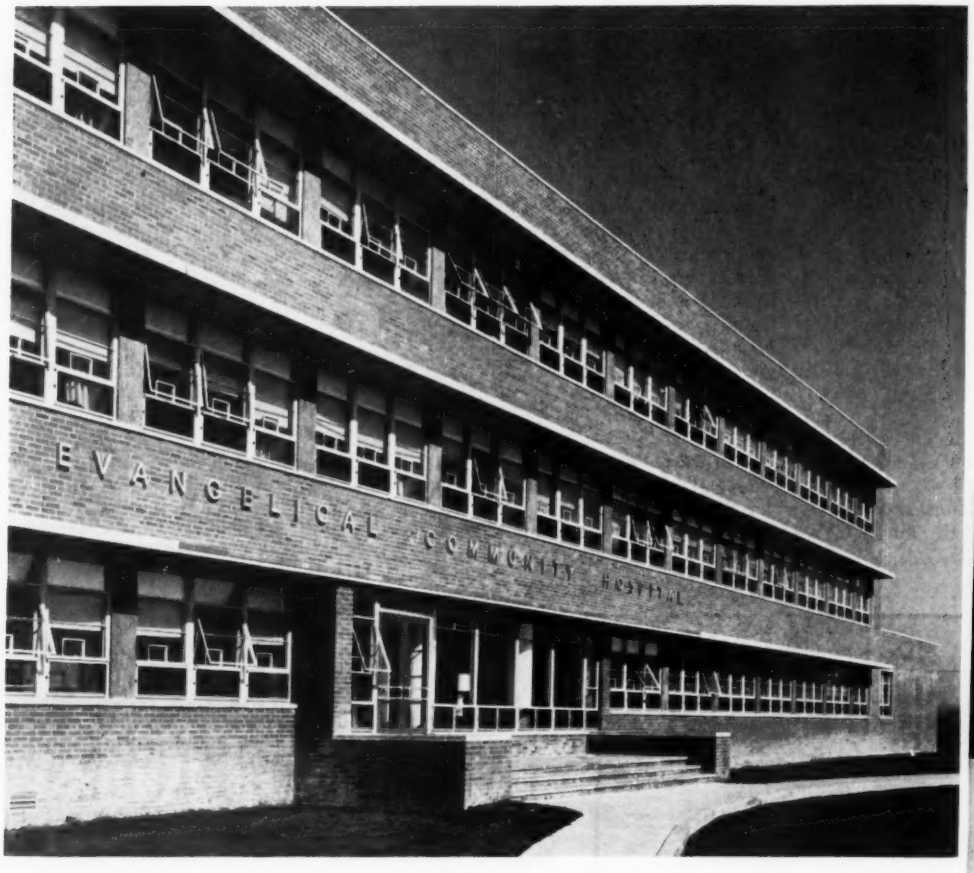
A FEW OF OUR MANY HOSPITAL ACCOUNTS*

*Baton Rouge Hospital
*Cerebral Palsy Hospital
*Anderson County Hospital
*Kings Daughters Hospital
*Mt. Sinai Hospital
*Sloan Kettering Institute

*Exact addresses furnished on request

"BRONZE TABLET HEADQUARTERS"
UNITED STATES BRONZE SIGN CO., INC.
570 Broadway Dept. MH New York 12, N. Y.





Evangelical Community Hospital, Lewisburg, Pa. Architects: Laurie & Green, Harrisburg, Pa. Contractors: Ritter Brothers, Harrisburg, Pa. Windows: Lupton Steel Architectural Projected. Photo—Wurts Bros.

Control Ventilation with Lupton Windows

One reason why the architects chose Lupton Architectural Steel Projected Windows for this new hospital was to efficiently control ventilation. When the windows are closed, double weathering contact on all sides of the sash assures minimum air infiltration. When open, two ventilating sash permit a choice of ventilation to suit patient, and weather. An open-out sash at the top shields the opening from rain and bad weather. The open-in sash at the bottom directs air flow upward, prevents direct exposure and provides better air circulation.

Sturdy steel makes it possible for window members to be trim and narrow for beauty and strength without bulk. And . . . here are windows that will keep their beauty and efficiency. They will not warp, shrink, rattle or swell. Lupton Metal Windows need a minimum of attention through the years — a vital concern to your operating budget.

Ask your architect about Lupton Metal Windows, there's a type for every building. Available in Steel or Aluminum, Lupton Metal Windows offer you one of the best buys on the market — as they have for over 40 years. You can also get full details from the nearest Lupton Representative, or write direct.

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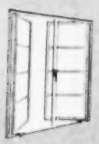
700 East Godfrey Avenue, Philadelphia 24, Pa.

LUPTON METAL WINDOWS

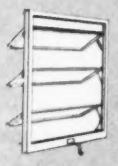
QUALITY APPROVED

Member of the Steel Window Institute and Aluminum Window Manufacturers' Association

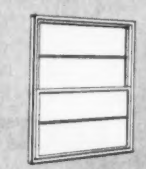
LUPTON MASTER ALUMINUM PROJECTED WINDOW



LUPTON CASEMENT ALUMINUM OR STEEL



LUPTON ALUMINUM AWNING WINDOW



LUPTON ALUMINUM DOUBLE HUNG WINDOW

What's New . . .

Pharmaceuticals

Tarquinor

Tarquinor is a crude coal tar cream for the treatment of a wide range of skin disorders. It contains rigidly standardized whole crude coal tar but is so compounded that it does not discolor the skin or stain clothing. The crude coal tar is made water-soluble in Tarquinor and the cream also contains Quinolor, a potent antibacterial agent to prevent folliculitis and to combat secondary infections. It is supplied in one ounce plastic unbreakable jars and one pound glass jars. **E. R. Squibb & Sons, Dept. MH, 32-14 Northern Blvd., Long Island City 1, N.Y. (Key No. 550)**

Thiosulfil Suspension

Thiosulfil Suspension for the treatment of urinary tract infections is now available. This sulfonamide is now offered in suspension form as well as in tablets. It is markedly soluble in the free and acetyl forms, is rapidly absorbed and excreted, and effective urinary concentrations can be rapidly obtained with low dosage levels and minimum danger of side effects. It is supplied in bottles of 4 and 16 fluid ounces. **Ayerst, McKenna and Harrison Ltd., Dept. MH, 20 E. 40th St., New York 16. (Key No. 551)**

Erythrocin With Sulfas

Erythrocin With Sulfas is a new buffered tablet designed to provide rapid blood levels within the minimum inhibitory levels for most susceptible organisms. The tablets are "Film-Sealed" to facilitate swallowing and to seal-in the taste of the drug completely. The special buffer protects the tablets from gastric secretions and makes for swift absorption in the upper intestinal tract. The drug is effective against infections, especially in patients allergically sensitive to other antibiotics, or where the organism is resistant. **Abbott Laboratories, North Chicago, Ill. (Key No. 552)**

Panalins and Panalins-T

Two new products have been introduced which conform precisely to standards established by the Food and Nutrition Board of the National Research Council in its report on Therapeutic Nutrition. Panalins and Panalins-T are vitamin capsules containing B complex vitamins and vitamin C. Panalins-T is designed for therapeutic administration while Panalins fills the need for routine maintenance. Panalins is supplied in bottles of 100 and 500 capsules, and Panalins-T in bottles of 30 and 100 capsules. **Mead Johnson & Company, Dept. MH, Evansville, Ind. (Key No. 553)**

(Continued on page 250)

Tridipigen

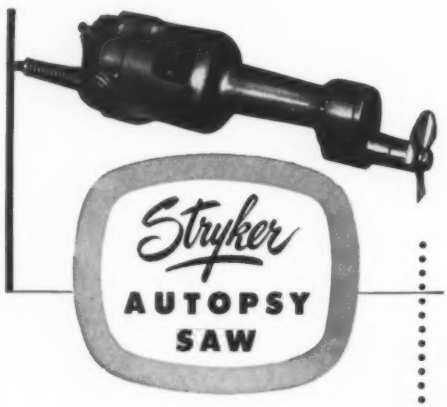
Two new products for immunizing simultaneously against diphtheria, whooping cough and tetanus have been introduced by Lilly. Tridipigen, Alum Precipitated is recommended when immunization is begun before the age of six months. Tridipigen, Fluid, is for immunizing any adult or any child six months or older. **Eli Lilly and Company, Indianapolis 6, Ind. (Key No. 554)**

Serpasil

Serpasil is a pure crystalline alkaloid of Rauwolfia serpentina. It produces mild; gradual, sustained lowering of blood pressure without serious side effects. It is effective alone or in combination with other antihypertensive agents, has uniform potency and predictable results. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N.J. (Key No. 555)**

Rauvera

Rauvera is a hypotensive agent in tablet form biologically standardized for hypotensive activity. It exerts a mild hypotensive action, provides sedation, a mild bradycrotic influence and induces a sense of well-being. It is supplied in bottles of 100 tablets. **Smith-Dorsey, Lincoln, Nebr. (Key No. 556)**



A new instrument which simplifies bone cutting

Electrically driven, oscillates at high speed to cut bone efficiently with complete safety. Cutting blades do not hurl material. Two-sided blade can be adjusted to three positions. Blade, arbor and shaft are stainless steel.

Dept. H

ORTHOPEDIC FRAME COMPANY Kalamazoo Michigan

AMERICA'S GREATEST NAME IN HOSPITAL CUBICLES!

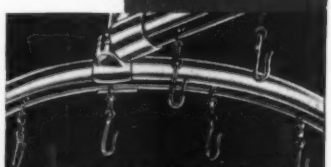
CAPITAL CUBICLES

Meets every requirement for complete privacy, smooth, efficient operation, ease of installation and elimination of maintenance expense.

Available in:
BRASS
STAINLESS STEEL
LUSTROUS FINISH ALUMINUM

SEND FOR ADDITIONAL DETAILED INFORMATION

. . . include rough sketch of room, indicating bed positions. We will submit plans, specifications and cost. No obligation, of course.



CURTAIN HOOKS OPERATE INSIDE TRACK . . . CANNOT BE REMOVED OR LOST CANNOT SCRATCH FINISHED SURFACE

CAPITAL CUBICLE CO., INC.
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Affiliates:
BAR-RAY PRODUCTS, INC.
X-Ray Accessories and Protection
TORJESEN, INC.—Cabinet and Mill Work

Chamberlin Security Screens can be ordered with special emergency release permitting instant patient removal by operation of lock from outside building. Special key opens all screens from inside.

Reduce the threat of disaster, too, with Chamberlin Security Screens

You reduce the threat of disaster. No grilles, no bars to trap patients in case of fire. No stubborn or jammed locks to hinder rescue operations. Exclusive Chamberlin locks permit *instant* patient removal from outside in emergencies.

You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

You reduce sash repair and paint costs. Chamberlin Security Screens mounted at recommended distances from window help prevent mutilation of window frames, sash, paint.

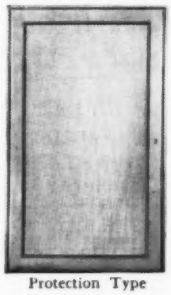
You reduce grounds maintenance costs. Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects.

You eliminate insect screen costs. Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands usual abuse. Admits ample light and air.

Over the years, these savings will more than offset your original screen costs. Yet they're only a few of the savings and services other hospital administrators receive every day (see right). Let our Hospital Advisory Service give you full details. Write today.

The right screen at the right cost to fit your patients' needs

Detention Type



Protection Type

Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for non-violent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings: Replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: Prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICH.

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Calking, All-Metal Combination Windows, Insect Screens, Building Cleaning, Tuck Pointing, and Waterproofing.

What's New . . .

Product Literature

• Over 700 items of equipment for hospitals and physicians are listed in the new **Catalog No. M-154** issued by Brooklyn Hospital Equipment Co., Inc., Dept. MH-9, Johnstown, Pa. The catalog is a helpful reference book on equipment from major operating tables to footstools, cabinets, stands, tables, beds, wheeled equipment, screens and other products. Stainless steel equipment is illustrated and described in a special section and a color chart shows the many colors of Resistal enamel available as finish on the equipment. **(Key No. 557)**

• The latest model **Penfield Permanent Cartridge Demineralizer with Laboratory Stand** is described in a new brochure released by Penfield Mfg. Co., Inc., 19 High School Ave., Meriden, Conn. The new laboratory demineralizer is shown in use, there is an operating diagram, and data and advantages are given in the text. **(Key No. 558)**

• A new catalog has been issued by Barber-Colman Company, Rockford, Ill., covering **Barber-Colman Electronic Controls for Heating, Ventilating and Air-Conditioning. Catalog F 6166** describes the flexibility of the controls system and gives descriptive information on the various elements required. **(Key No. 559)**

• A 42 page handbook of cleaning has been issued by Oakite Products, Inc., 118A Rector St., New York 6. Entitled, **"How to Make Power Plant Cleaning Easier,"** the booklet is divided into sections on cleaning equipment in steam central stations, power plants and descaling. **(Key No. 560)**

• A new edition of the **Holophane Datalog** has been released by the Holophane Company, Inc., 342 Madison Ave., New York 17. This 64 page and cover catalog describes all Holophane products for modern illumination including lighting units designed and engineered for specific purposes. General information on light control, illumination levels, lighting design, coefficients of utilization and institutional lighting start the story of lighting and lighting fixtures. Each lighting fixture is described and illustrated by photographs and drawings, including a chart of the candlepower distribution. **(Key No. 561)**

• The operation and advantages of a **Municipal Fire Alarm Box System** are discussed in a new 24 page booklet published by The Gamewell Company, Newton Upper Falls 64, Mass. The information should be of interest to administrators as well as to all citizens who are interested in fire protection. **(Key No. 562)**

• Engineering data on a complete range of sizes and types of Vogt Refrigeration Condensers for refrigeration service are given in **Bulletin RC-2** issued by Henry Vogt Machine Co., Louisville 10, Ky. General data on refrigeration condensers is followed by a discussion of how to select the proper condenser, information on large and small ammonia and Freon condensers, dimensions and sizes. Data are given in tables and the catalog is fully indexed. **(Key No. 563)**

• **Extendoor, "The Folding Door With the Extendible X,"** is discussed in an attractively laid out and printed folder recently received from Extendoor, Incorporated, Muskegon, Mich. Where these smooth, quiet, easily moved folding doors can be used advantageously is shown in a series of photographs. Methods of installation and mechanical accessories are not only described but line drawings illustrate each point covered. Full specifications are included as is information on Extendoor Hardware. **(Key No. 564)**

• Thirty-two different types of trucks for easy and safe handling of various types of materials are described in the new pocket sized **Booklet 53-S** issued by Nutting Truck and Caster Co., Inc., Faribault, Minn. Specifications and descriptions of the trucks are supplemented with how-to-use information. **(Key No. 565)**

(Continued on page 252)

EDWARD DON & COMPANY

For "Modified Diets" or Regular Feeding

YOU can prepare your patients' meals with more efficiency and less cost. That important expense may be cut considerably without impairing calorie-content. The preparation and serving of foods may be handled quicker, more thoroughly and with less lost motion by using DON—

EQUIPMENT • FURNISHINGS • SUPPLIES

Even a general or "special diet" kitchen may be obsolete or antiquated and may need modernizing. Dish washers, food mixers, apple parers, potato peelers, food carts and other equipment will save time. These and others of the 50,000 items you may need are sold by DON. Every item sold on a guarantee of satisfaction or money back.

Write Dept. 14 for a DON salesman to call — or in Chicago phone CAlumet 5-1300.

EDWARD DON & COMPANY
Miami 32 CHICAGO 16 Minneapolis 1

YOU GET CLEAN FLOORS

FASTER... EASIER... AT LOWER COST...

WITH Geerpres WRINGERS

Twin Tank "Floor-King" model for 20 to 36 oz. mops.

Designed to Take the Drudgery Out of Mop Wringing.

ONLY GEERPRES WRINGERS....

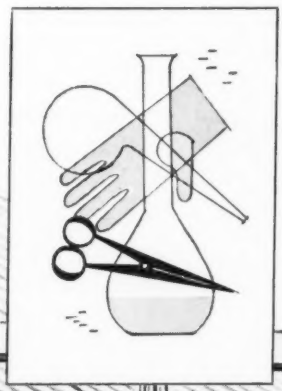
(1) Squeeze mops drier (3) Prolong mop life
(2) Wring mops uniformly (4) Eliminate all splash

Fully guaranteed. Available in two styles and three size ranges to meet all your mop wringing requirements. Write for further information to:

GEERPRES WRINGER, INC.
Manufacturers of High Grade Mopping Equipment
P.O. BOX 658 • MUSKEGON, MICHIGAN

Goodall specializes in serving YOU!

Blended-to-Perform Fabrics are created and designed to fit your specific needs...



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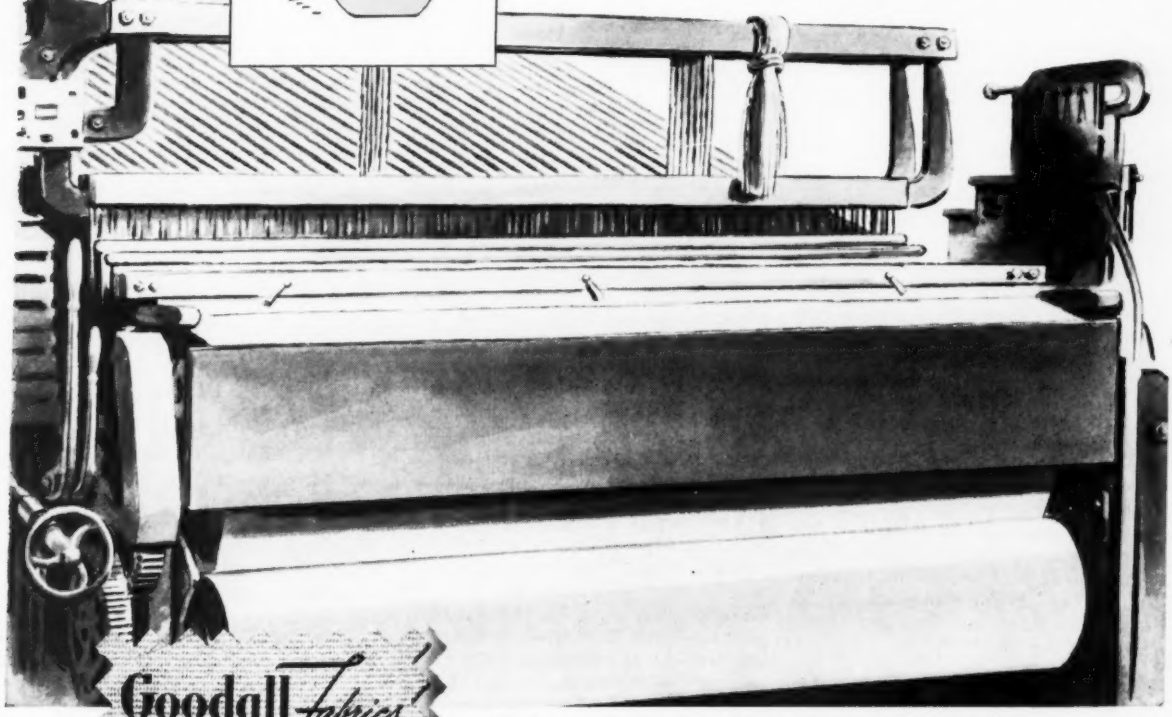

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March, 1954

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Aro-Brom's clear dilution in tap water guarantees uniform effectiveness.

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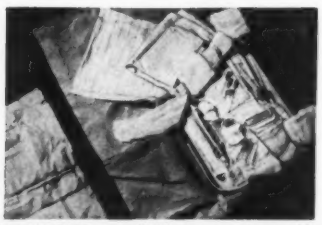

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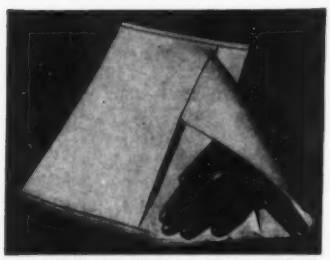

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